NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

Adopted by the Executive (EX) Committee/Plenary
May 12, 2010

NAIC Response to Request for Information Regarding Section 2718 of the Public Health Service Act

The questions below are from the Federal Register on April 14, 2010. Responses are in *italics*.

General Comment

Several of the specific questions ask what states require or how they will be impacted. We surveyed the states concerning these questions. Due to time constraints, responses were only received from 27 states. A spreadsheet showing the responses is being submitted with this document. America's Health Insurance Plans (AHIP) publishes a chart with information about the requirements of all states that have such requirements. As part of our survey, we asked the states to verify the information in the AHIP chart. Several corrections were noted and are shown in the first row of the spreadsheet. On the whole, it appears the AHIP chart is fairly accurate, although some details and nuances are not reflected. For the states that did not respond to our survey, we believe the AHIP chart is the best readily available source of information, with the caveat that it contains some inaccuracies.

A. Actual MLR Experience and Minimum MLR Standards

1. How do health insurance issuers' current medical loss ratios for the individual, small group, and large group markets compare to the minimum standards required in PPACA?

It is difficult to compare, because the definition of medical loss ratio (MLR) in PPACA is quite different from the MLR typically used by the NAIC and various states. Typically, MLRs currently in use do not adjust premiums for taxes, and do not increase claims by quality improvements. Both of these adjustments will result in a higher MLR than one calculated as incurred claims divided by earned premiums with no adjustment. We believe current MLRs for most issuers in the small group and large group markets, when calculated with the PPACA adjustments and applied to the entire market within a state, would be higher than the PPACA minimums. To the extent data is disaggregated, there might be particular categories where the standard would not be met. The situation is less clear in the individual market. Some issuers would likely have aggregate MLRs below 80% in at least some states even after the adjustments, while others would be well above the minimum.

Some states publish MLRs for issuers in the individual and small group medical markets. For example, Minnesota's loss ratio report can be viewed at http://www.state.mn.us/portal/mn/jsp/content.do?rc_layout=bottom&agency=Insurance&id=-536893705&programid=536915531.

a. What factors contribute to annual fluctuations in issuers' medical loss ratios?

Several factors result in fluctuations from year to year, including, but not limited, to the following:

- *The smaller a block of policies is, the more claims will fluctuate due to random variations. For example, one large claim can cause a sharp increase in the MLR for a very small block. In fact, large claims can have a significant* ***impact*** *on even relatively large blocks. This impact could now be amplified because many plans now include lifetime and other limits that are eliminated by PPACA, making the exposure to large claims greater than the current exposure.*
- *Rates are generally set based on projected claims trends, which in turn are based on past claims trends and expectations about future changes. Actual claims trends will usually turn out to be higher or lower, resulting in fluctuations in the MLR.*
- *Unforeseen short-term changes in the morbidity of a population can affect loss ratios. Pandemics or even unusually severe flu seasons are examples.*
- *In some markets for some time periods, cyclical variations have been observed where MLRs are lower for a few years and then higher for a few years. This is called the "underwriting cycle," and the causes have not been definitely determined.*

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- *For individual policies, especially in the majority of states where medical underwriting is permitted, MLRs are much lower in the early years after a policy is issued and increase over time as underwriting "wears off" and health problems not present at the time of underwriting develop. If the block of policies being measured contains a steady mix of older and newer policies, they will offset each other, but for a relatively new plan, where all of the policies are in their early years, the MLR in the first year can be as low as half of the ultimate level. Conversely, for a block of policies no longer being issued, all of the policies will be in their later years and have higher loss ratios. This effect should lessen over time after 2014, when medical underwriting will be prohibited, but is unlikely to completely disappear.*

b. To what extent do States have different minimum MLR requirements based on plan size, plan type, number of years of operation, or other factors?

See General Comment above and the spreadsheet submitted with this document.

2. What criteria do States and other entities consider when determining if a given minimum MLR standard would potentially destabilize the individual market? What other criteria could be considered?

The primary factor is the extent to which issuers would be unable or unwilling to meet the standards, and would therefore withdraw from the market and terminate existing policies. In the worst case, this could lead to a lack of available coverage. Even if coverage remains available, those with health conditions who are terminated by withdrawing issuers could be left with no access for up to six months, because in most states, issuers will be permitted to medically underwrite until 2014. After six months, they would qualify for the new federal high risk pools.

The American Academy of Actuaries (AAA) has noted three ways in which the MLR standard could cause disruption to consumers in the individual market:

"1. Applying an 80 percent MLR requirement to existing individual business that had originally been priced under different (lower) MLR expectations may require a company to reduce the premiums it ultimately retains (i.e., collected premiums less rebates) to levels that create losses, with little to no ability to recover those losses. Materially reducing the non-claims costs associated with existing business in order to reduce financial losses is unlikely to be feasible. Such a situation might lead some companies currently active in the individual market to terminate the existing blocks of business and leave the market, in an effort to avoid those future losses and the potential solvency concerns associated with those future losses. If some companies do exit the individual market, then those companies' former policyholders may find themselves unable to find new coverage in the individual market for a period of years (noting that guaranteed issue requirements do not take effect until 2014), and would not be eligible for the new high risk pools created by PPACA §1101 during the first six months after cessation of coverage.

"2. Individual policies underwritten and issued prior to the introduction of guaranteed issue requirements in 2014 will continue to exhibit traditional patterns of having loss ratios that increase by policy duration. Issuing new underwritten policies over the next few years would therefore tend to make it more difficult for an insurer to achieve an 80 percent annual MLR across its entire block of individual medical business. This could serve as an incentive for carriers who remain in the individual market to minimize their marketing activity prior to 2014, creating a potential lack of product availability in the individual market over the next few years.

"3. Since the MLR for underwritten individual products typically increases with policy duration, a company whose individual book of business has a higher proportion of recently-sold business may find it more difficult to achieve an 80 percent annual MLR in the near future than a company having a more mature book of business (and a correspondingly higher MLR). As such, the application of uniform annual MLR requirements could have a disproportionate impact across companies, which could lead to additional volatility in premium and rate change levels in the individual market."[1]

[1] *Letter from the AAA Medical Loss Ratio Regulation Work Group to Lou Felice, Chair, NAIC Health Care Reform Solvency Impact Subgroup, and Steven Ostlund, Chair, NAIC Accident and Health Working Group.*

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We note that most of these issues arise only during the period prior to 2014. It may be desirable to reduce the minimum MLR in the individual market in many states during this initial period.

B. Uniform Definitions and Calculation Methodologies

1. What definitions and methodologies do States and other entities currently require when calculating MLR-related statistics?

See General Comment above and the spreadsheet submitted with this document.

a. What assumptions and methodologies do issuers use when calculating MLR-related statistics? What are some of the major differences that exist, as well as pros and cons of these various methods?

Issuers may use different methodologies for different purposes, such as internal monitoring, financial statements and rate filings. Financial statements filed with the U.S. Securities and Exchange Commission (SEC) follow generally accepted accounting principles (GAAP). Statutory financial statements filed with the NAIC and the states follow statutory accounting, which is based on GAAP but differs in ways set forth in Statements of Statutory Accounting Principles (SSAP). The loss ratio in the NAIC Accident & Health (A&H) Policy Experience Exhibit includes incurred claims, plus the change in contract reserves in the numerator and earned premiums in the denominator. No administrative expenses are included in the numerator and no reductions to earned premium are made for taxes and fees. Because the statement must be completed soon after the end of the year, incurred claims reflect an estimate of the "runout" — that is, the amount that will be paid after the end of the year on claims incurred during the year. The runout amount cannot be exactly calculated for at least 12 months, because many states require the issuer to accept a claim that is submitted within 12 months after the service date.

For rate filings, the methodology will depend on the requirements of the each state. Typically, incurred claims for past years are restated to reflect actual runout. This gives a more accurate result because the runout amounts can vary significantly from initial estimates. Some states include cost containment expenses in the numerator, while others do not. Still others do not specify, in which case the issuer may include these expenses.

For experience-rated group products, the claims are often calculated based on six months of paid claims after the end of the experience period.

For purposes of the new federal requirement, the extent to which actual runout can be reflected rather than an estimate will depend on how soon the loss ratios must be reported after the end of the year. The advantage to allowing more time is that the incurred claims will be more accurate and less dependent on assumptions. The trade-off would be the delay in determining and paying rebates. One possibility would be to include the increase in the estimated liability for unpaid or unreported claims over the prior year. In that way, an inaccurate estimate will to some extent be corrected the following year. However, that would not be the case if the liability were consistently over- or under-estimated. If the liability ***used is from*** *the NAIC annual financial statement, that estimate is required to be on a conservative basis because its purpose is to ensure solvency.*

The administrative expenses to be included in the numerator will depend on interpretation of the statute, as discussed under question (c) below.

b. What kinds of assumptions and methodologies do issuers currently use for allocating administrative overhead by product, geographic area, etc.? What are the pros and cons of these various methods?

Issuers use a variety of methods and assumptions when allocating expenses that are not directly attributable to one product and/or geographic area. They may allocate by premiums, by number of covered lives, by number of claims, by direct expenses, by reserves or by time studies. In most cases, a combination of methods will be used, with different types of expenses being allocated in different ways. For example, billing expenses might be allocated by number of policies, while claims administrative expenses might be allocated by number of claims.

c. What kinds of assumptions and methodologies do issuers currently use when calculating the loss adjustment expense (or change in contract reserves)? What are the pros and cons of these various methods?

Loss adjustment expense and the change in contract reserves (as the terms are generally used) are different things. Loss adjustment expenses (or claim adjustment expenses) are administrative expenses associated with the payment of claims. For financial reporting purposes, the specific expenses to be included are spelled out by the NAIC[2] and are subdivided into two categories: (1) cost containment expenses such as case management, utilization review, fraud prevention and network access fees; and (2) other claim adjustment expenses, such as determining and paying claims, recordkeeping, office expenses, and supervisory and executive duties. It is unclear whether these are the types of expenses intended by the term "loss adjustment expense" in PPACA, or whether the parenthetical indicates that in this context "loss adjustment expense" is intended to mean the change in contract reserves.

Contract reserves are liabilities shown in the issuer's financial statement to reflect the extent to which future premiums are not expected to be adequate to pay future benefits or part of the premium in early durations is intended to pay claims in later durations. Contract reserves are not as common for medical insurance as for other types of insurance, such as long-term care insurance, where premiums are usually based on the age of the insured at the time the policy was issued, while claims increase each year as the person ages.

It is appropriate to reflect the change in contract reserves to the extent it reflects benefits to be paid in the future that must be funded by the current year's premiums. State regulatory requirements set forth methodologies and assumptions that define a minimum level for contract reserves when needed. Adequate reserves are essential to ensure solvency. However, for purposes of minimum loss ratios, it is also important that reserves are not overstated. Reserves should not be based on unrealistic assumptions that would inflate the loss ratio. Financial examinations are focused primarily on solvency. While examiners do evaluate the reserves to identify possible redundancies that are outside a reasonable range, smaller redundancies are not a concern in exams. Also, statutory reserves are required to have a margin so that the majority of the time they will be at least sufficient. For loss ratio calculations, a reserve without margins may be more appropriate. Excessive reserves could result in significantly higher MLRs for several years. Regulatory review will be needed to ensure the reserves are not overstated.

Similarly, if loss adjustment expenses are to be included in the loss ratio, it is important that reasonable allocation methods be used to separate these expenses from other administrative expenses.

d. To what extent do States and other entities receive detailed information about the distribution of non-claims costs by function (for example, claims processing and marketing)? To what extent do they set standards as to which administrative overhead costs may be allocated to processing claims, or providing health improvements?

See General Comment above and the spreadsheet submitted with this document.

The NAIC annual financial statement, which must be completed by all licensed insurers, includes an exhibit with a detailed breakdown of expenses. A copy of the exhibit for health insurers is appended to this response to show the specific expense types (Appendix A). Life insurers also offer health insurance and the annual statement for life companies contains a similar exhibit, but with some differences in the categories shown. Most notably, with the exception of cost containment expenses, the life company exhibit does not separate claim adjustment expenses from other administrative expenses. Also, a relatively small proportion of health insurance is issued by property and casualty companies, which also contains a similar but not identical exhibit. For all three types of companies, the data may include types of policies other than those to which the new federal MLR requirements apply. The data is on a national basis and is not split by state. As noted in the response above, the specific expenses to be included in claim adjustment (claims processing) expenses are spelled out in SSAP No. 85.

e. What kinds of criteria do States and other entities use in determining if a given company has credible experience for purposes of calculating MLR-related statistics?

See General Comment above and the spreadsheet submitted with this document. The NAIC will provide recommendations relative to pooling and credibility by June 1.

f. What kinds of special considerations, definitions, and methodologies do States and other entities currently use relating to calculating MLR-related statistics for newer plans, smaller plans, different types of plans or coverage?

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[2] *Statement of Statutory Accounting Principles (SSAP) No. 85—Claim Adjustment Expenses.*

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See General Comment above and the spreadsheet submitted with this document.

2. What are the similarities and differences between the requirements in Section 2718 compared to current practices in States?

See General Comment above and the spreadsheet submitted with this document.

a. What MLR-related data elements that are required by PPACA do issuers currently capture in their financial accounting systems, and how are they defined? What elements are likely to require systems changes in order to be captured?

We have no information to offer at this time.

b. What MLR-related data elements that are required by PPACA do States or other entities currently require issuers to submit, and how are they defined? What elements are not currently submitted?

See General Comment above and the spreadsheet submitted with this document.

3. What definitions currently exist for identifying and defining activities that improve health care quality?

See General Comment above and the spreadsheet submitted with this document.

a. What criteria do States and other entities currently use in identifying activities that improve health care quality?

See General Comment above and the spreadsheet submitted with this document.

b. What, if any, lists of activities that improve health care quality currently exist? What are the pros and cons associated with including various kinds of activities on these lists (for example disease management and case management)?

See General Comment above and the spreadsheet submitted with this document.

Including quality expenses in the numerator of the MLR for rebate purposes will create a strong incentive for issuers to classify as many expenses as possible in this category. Therefore, it is important to not only specify the types of activities to be included by name, but also to distinguish between different activities that might have the same name. For example, a "case management" program typically includes activities intended to improve continuity and quality of care, but it is not difficult to imagine a utilization review program being renamed a case management program. The states can monitor the actual operation of quality improvement programs through market conduct reviews.

It also may be advisable to distinguish between activities that improve quality and those that only reduce costs or transfer costs to the consumer. While reducing costs may be desirable, the statute only refers to improving quality. Quality improvement expenses might include things such as statistical measurement systems such as the Healthcare Effectiveness Data and Information Set (HEDIS). Cost reduction activities might include things such as utilization review and statistical activities to ensure correct coding. While it is important that the list of qualifying activities not be overly broad, there may also be a risk that a list that is too narrow or inflexible could discourage innovation in the improvement of health care quality.

These issues are still under discussion within the NAIC. We will provide more specific comments and recommendations by June 1.

c. To what extent do current calculations of medical loss ratios include the amount spent on improving health care quality? Is there any data available relating to how much this amount is?

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See General Comment above and the spreadsheet submitted with this document.

4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

Rebates are based on the "plan year." It is not clear whether this means the plan year for each employer (as defined by ERISA) or a calendar year or some other 12-month period applicable to all of an issuer's policies. Insurers report financial results on a calendar-year basis. These could not be used as a basis for loss ratio reporting if loss ratios are to be reported for a different period. Also, if plan year is determined at the employer level, a method would need to be a specified for combining the results for plans with differing plan years, such as combining all plan years that end during a given calendar year. It is important to note that many employer plans have a non-calendar plan year, perhaps to coincide with the employer's fiscal year, but use a calendar year for the benefit period used to accumulate deductibles and out-of-pocket limits.

In addition, if plan year is determined at the employer level, some other definition would be needed for the individual market. Some issuers set a particular month for all individual policies to renew. Then, any policies sold during another month will have a short or long plan year for the first period, and then subsequent plan years start on the month when all the policies renew. Some others renew monthly, so there is no "plan year."

We note that the U.S. Department of Health and Human Services recently issued regulations that define "plan year" for purposes of reinsurance for early retirees and for purposes of dependent coverage of children to age 26. However, different definitions may be appropriate for different purposes.

C. Level of Aggregation

1. What are the pros and cons associated with using various possible level(s) of aggregation for different contexts relating to implementation of the provisions in Section 2718 (that is, submitting medical loss ratio-related statistics to the Secretary, publicly reporting this information, determining if rebates are owed, and paying out rebates)?

The NAIC will submit by June 1 our recommendations relative to aggregation, pooling and credibility. Following are our preliminary thoughts on the questions raised.

Submitting MLR-related statistics: The extent to which experience should be separated for reporting purposes should be determined by how the data will be used. Specifically, it will have to be reported separately to the extent needed for public reporting and for determination of rebates. These are discussed below. If a different level of aggregation is used for rebate determination, it might be desirable to make that report publicly available, as well, so that consumers can determine whether they are eligible for a rebate. It might also be desirable to have data submitted at a less aggregated level than will be used for either public reporting or rebate determination. For example, reporting at the plan level might be desired for auditing purposes.

Publicly reporting: This might depend on the intended audience. Some consumers might find higher levels of aggregation easier to understand, and might be overwhelmed by detailed breakdown. More detail might be of interest to others and to policy analysts. One option would be to offer more than one configuration of the data.

Determining if rebates are owed: At a minimum, business subject to different loss ratio standards must be treated separately. Therefore, large group business must be treated separately, because it is subject to a higher standard (unless a state requires the same standard for small groups). It would also be preferable to treat the small group and individual markets separately, except in states that combine the two markets. It is generally more difficult to meet the 80% minimum standard in the individual market, due to the higher administrative expenses associated with marketing and servicing policies at the individual level. If the two markets are treated together for purposes of determining rebates, an issuer with business in both markets could use higher small group loss ratios to offset lower individual loss ratios. This would create an "unlevel playing field" for issuers in only the individual market. Also, it would mean individual policyholders might not get rebates to which they are arguably entitled.

The question of further disaggregation within a market is a more difficult one. One key consideration is credibility. If a block of business is too small, the experience will not be credible, meaning it is subject to random statistical fluctuation resulting in

a very low loss ratio in some years and a very high one in other years, perhaps due to one or two large claims. We note that beginning in 2014, three years of experience will be used, which will improve credibility. For sufficiently large blocks of business, it might make sense to treat different types of products separately if they are rated on different bases. One possibility would be to separate health maintenance organization (HMO), preferred provider organization (PPO) and indemnity business. Further breakdown, such as by policy form, might be feasible if the block is large enough.

There are good arguments for and against more granularity (less aggregation) for rebating purposes. It might prevent a carrier from charging excessive rates on one segment of its business and offsetting the low loss ratios with lower rates on a segment where the market is more competitive. On the other hand, it could have the unintended consequence of higher premiums. Currently, a carrier can offset losses due to unfavorable experience on one product with gains from favorable experience on another. If the gains must be paid out in rebates, higher rates might be needed to build in more risk margin.

Potentially, an issuer could maximize profit by setting rates so high that almost every policy gets a rebate. Presumably, normal price-shopping would not apply, because the purchasers would expect a rebate of any premium over the minimum MLR.

As a general principle, it might be desirable to combine blocks if they are intended to produce similar profit margins (but might not due to unexpected variations in experience) and to separate blocks if they are intended to offset competitive rates on one block with excessive rates on another. The catch is that it might be difficult to distinguish between the two. One approach would be to combine blocks for rebate determination and address any rate inequities through the rate review process.

Also, more granularity could be problematic for a new product, particularly in the medically underwritten individual market, because loss ratios are low in the early durations. (This could be a problem even with more aggregation if all of the company's business is in early durations.)

Another consideration is that more aggregation might be appropriate for those states that currently have some form of community rating in the small group and/or individual market. To the extent that rebates are based on a subset of the market rather than the whole market, it amounts to experience rating that subset. So, if that subset has better risks (younger and/or healthier), those members will reap the benefits of that, in effect defeating the principle of community rating. After 2014, modified community rating will apply in all states. A risk adjustment mechanism that equalizes the differences between different risk pools for different products could eliminate (or at least reduce) this "experience rating" effect. The risk adjustment mechanism in the federal law appears to only adjust between different issuers, not different plans issued by the same issuer, but the states could extend the system to apply within companies.

In the large group market, it would be appropriate to treat single employers separately to the extent their plans provide for experience refunds (retrospective rating). If these groups were combined with others with lower MLRs and thereby received a rebate, they would in effect be doubly rewarded.

In any event, if blocks within a market within a state are to be treated separately, there should be provisions for combining smaller blocks based on some standard of credibility.

Under any methodology, some people will believe they have not received the appropriate rebate. For example, many enrollees in individual high-deductible policies do not have any claims during a given year. As such, they might be unhappy if they get the same 4% rebate as an enrollee who had a lot of claims paid.

Paying out rebates: Although Section 2718 specifies that rebates are to be provided to each enrollee, this might be unreasonable in cases where all or some of the premium was paid by the employer or some other entity. If possible, it would be more equitable to pay the rebate to those who paid the premium. In the common situation, where both the employer and the employee contribute toward the premium, the rebate should be prorated. This may require the employer to provide information concerning employee contributions because the issuer may not have this information. Alternatively, the issuer could pay the rebate to the employer and the employer could be required to pay a prorated portion to employees.

2. What are the pros and cons associated with using various possible geographic level(s) of aggregation (e.g., State-level, national, etc.) for medical loss ratio-related statistics in these same contexts (i.e., submitting medical loss ratio-

related statistics to the Secretary, publicly reporting this information, determining if rebates are owed, and paying out rebates)?

The NAIC will submit by June 1 our recommendations relative to aggregation, pooling and credibility. Following are our preliminary thoughts on the questions raised.

Submitting MLR-related statistics: The extent to which experience should be geographically separated for reporting purposes should be determined by how the data will be used. Specifically, it will have to be reported separately to the extent needed for public reporting and determination of rebates. These are discussed below.

Publicly reporting: It would be reasonable to report loss ratios at the same level of geographic aggregation used for determining rebates, discussed below.

Determining if rebates are owed: At a minimum, business subject to different loss ratio standards must be treated separately. Because the states can establish different MLR standards, each state should be treated separately, except perhaps in the case of those states that have combined their markets through an interstate compact, once that option goes into effect in 2016. Although it might be possible to combine non-compacting states that have the same MLR standard, it would generally not be equitable because rating standards may vary. For example, if rates are higher in State A than in State B because State B regulates rates more tightly, and as a result the loss ratio is below the minimum in State A, combining the experience for both states would result in (1) no rebates (if the combined experience met the minimum standard); or (2) smaller rebates in State A and unwarranted rebates in State B. One exception might be an issuer that does not have enough business in a state to be credible. In that case, it might be preferable to combine experience from several states with small amounts of business or, if that is still not credible, combine it with one or more states with larger amounts of business.

Business in different geographic regions within a state should not be separated unless there is a compelling reason to do so. For example, if rates are more competitive in one area of a state, perhaps because there is a low-cost HMO operating there but not in other parts of the state, ratepayers in other areas might not get rebates to which they are arguably entitled unless each area is treated separately. If areas are treated separately, it might be desirable to have an exception whereby the areas can be combined for an issuer with insufficient business in one area to be credible.

D. Data Submission and Public Reporting

1. To what extent do States or other entities currently require annual submission of actual medical loss ratio-related statistics for the individual, small group, and large group markets? How do these current requirements compare with the requirements in PPACA?

See General Comment above and the spreadsheet submitted with this document.

The NAIC annual financial statement, which must be completed by all licensed insurers, includes the "A&H Policy Experience Exhibit." This exhibit shows, separately for a variety of product types: (1) Premiums Earned; (2) Incurred Claims Amount; (3) Change in Contract Reserves; (4) Loss Ratio; (5) Number of Policies or Certificates as of Dec. 31; (6) Number of Covered Lives as of Dec. 31; and (7) Member Months. A copy of the exhibit is appended to this response to show the specific product types (Appendix B). The data is on a national basis and is not split by state. As noted above under question B1(a), the definition of the loss ratio in this exhibit includes only incurred claims plus the increase in contract reserves in the numerator and unadjusted earned premiums in the denominator.

2. How soon after the end of the plan year do States and other entities typically require issuers to submit the required MLR-related statistics? What are the pros and cons associated with various timeframes?

See General Comment above and the spreadsheet submitted with this document.

The NAIC annual financial statement is due March 1 of each year, but the A&H Policy Experience Exhibit is not due until April 1. Extensions may be granted in some cases.

Some of the claims incurred during a year will not be paid until after the end of the year. Amounts paid after the end of the year are sometimes referred to as "runout." Depending on when the MLR is calculated, some or all of the runout will be estimated. The longer the lag between the end of the year and the date the MLR is calculated, the greater the accuracy, because more of the runout will reflect actual experience and less will need to be estimated. Although some payments (or recovery of excess payments) may occur a year or more after the end of the year, the bulk of the runout will occur in the first month or two. Some lag will be needed between the time the MLR is calculated and the time it is reported to allow for checking and review. Therefore, a reporting date in the range of four to six months after the end of the year might represent a reasonable trade-off between accuracy and timeliness. Alternatively, as discussed under question B1(a), inaccuracies resulting from an early reporting date could, to some extent, be corrected the following year by including the change in the estimated liability for unpaid or unreported claims over the prior year.

3. What kinds of supporting documentation are necessary for interpreting these kinds of statistics? What data elements and format are typically used for submitting this information?

See General Comment above and the spreadsheet submitted with this document.

The data elements and format of the NAIC A&H Policy Experience Exhibit are shown in Appendix B.

4. What methods do issuers use for purposes of submitting medical loss ratio-related data to these entities (for example, electronic filing and paper filing)?

Some states may require a particular method while others do not. Methods include completing online forms, submitting spreadsheets, text or PDF documents by e-mail, fax submission or paper filing.

5. To what extent is MLR-related information submitted to States or other entities currently made available to the public, and how is it made available (for example, level of aggregation, and mechanism for public reporting)? What are the pros and cons associated with these various methods?

See General Comment above and the spreadsheet submitted with this document.

6. Are there any industry standards or best practices relating to submission, interpretation, and communication of MLR-related statistics?

The AAA has several relevant Actuarial Standards of Practice (ASOPs). We believe they will provide details in their response to this Request for Information.

7. What, if any, special considerations are needed for noncalendar year plans?

This question relates to the definition of "plan year" discussed above under question B4. If plan year is determined at the employer level, either the cohort of plans beginning in each month of the year must be treated separately or some methodology must be determined to combine experience for varying plan years. Treating each separately would be likely to result in credibility issues, because an issuer might have very few plans with plan years beginning in some months. Combining them would result in long delays between the end of some plan years and the date the MLR is reported. For example, if all plan years ending during a given calendar year are combined and the MLR is reported three months after the end of the year, then for plan years beginning Feb. 1, there will be 14 months between the end of the plan year and the reporting date.

E. Rebates

1. To what extent do States and other entities currently require MLR-related rebates for the individual, small group, large group, and/or other insurance markets, and how are these rebates calculated and distributed?

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2. How soon after the end of the plan year do States and other entities currently require issuers to determine if rebates are owed?

See General Comment above and the spreadsheet submitted with this document.

3. What are the pros and cons of various timeframes and methodologies for calculating rebates?

As discussed above under question D2, there is a tradeoff between allowing time for claims runout to achieve more accuracy and timely reporting and payment of rebates. A rebate determination date in the range of three or four months after the end of the year might represent a reasonable balance. Elements of the methodology include the level of aggregation, discussed above, and the items to be included in the numerator and the denominator. The latter is set forth in statute, but the language appears to be subject to interpretation.

4. How do States and other entities currently determine which enrollees should receive medical loss ratio-related rebates?[3] What are the pros and cons associated with these approaches?

See General Comment above and the spreadsheet submitted with this document.

The advantage to providing rebates to current policyholders would be administrative simplicity. Rebates could be deducted from current premiums, avoiding the need to issue checks. The disadvantage would be that those receiving the rebates would not always be the same as those who paid the premiums that generated the rebates. Paying rebates only to current policyholders who were enrolled in the coverage during the applicable time period would introduce some administrative complexity, but would avoid paying rebates to those who did not pay the premiums. Paying rebates to all policyholders who were enrolled in the coverage during the applicable time period, regardless of whether currently enrolled, would be the most equitable and the most administratively complex, as the issuer might not have current addresses for those who are no longer enrolled.

5. What method(s) do States and other entities currently require issuers to use when notifying enrollees if rebates are owed, and paying the rebates? What are the pros and cons associated with these approaches?

See General Comment above and the spreadsheet submitted with this document.

6. Are there any important technical issues that may affect the processes for determining if rebates are owed, and calculating the amount of rebates to be paid to each enrollee?

The law provides that beginning in 2014, rebates will be determined each year based on a three-year average. It is not clear how rebates paid in one year will affect the rebate calculation in subsequent years. If they are not reflected, a low loss ratio in one year could result in double or triple payment of rebates, as that year's experience will be included in the three-year average in three different years. If they are reflected as a policy benefit in the numerator (or perhaps as a reduction to earned premiums in the denominator), it will make a difference whether the rebate is reflected in the year it is paid or allocated among the year or years for which the experience gave rise to the rebate. If it is reflected in the year paid, it will be fully reflected in each of the next three three-year averages, resulting in a higher calculated MLR. If it is allocated to the year or years for which the experience gave rise to the rebate, amounts allocated to the period before the three-year average currently being calculated will not be considered. If the MLR was below the target in only one of the three years or in all three years, the allocation would be relatively straightforward. However, if the MLR was higher than the target in one year and lower in the other two, some thought would need to be given to how to allocate the rebate between the two low years.

<u>F. Federal Income Tax</u>

What guidance, if any, is needed for purposes of applying Section 833 of the Code for the first taxable year beginning after December 31, 2009?

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[3] For example: current policyholders; current policyholders who were enrolled in the coverage during the applicable time period; or all policyholders who were enrolled in the coverage during the applicable time period (regardless of whether they are still active policyholders).

It appears that the ratio referenced in Section 9016 is the one defined by Section 2718(a)(1), which would have clinical services in the numerator, without loss adjustment expenses or quality improvement expenses, and earned premiums in the denominator. Some guidance indicating this (or, if this is incorrect, the appropriate reference) would probably be useful. Also, it would be important to clarify whether federal and state taxes are to be deducted from earned premiums in the denominator. This deduction is included in Section 2718(b), but Section 2718(a) is silent on this question.

G. Enforcement

1. What methods do States and other entities currently use in enforcing medical loss ratio-related requirements for the individual, small group, large group, and other insurance markets (for example, oversight and audit requirements)? What other methods could be used?

See General Comment above and the spreadsheet submitted with this document.

2. What, if any, penalties do these entities currently apply relating to noncompliance with medical loss ratio-related requirements? What, if any, related appeals processes are currently available to issuers?

See General Comment above and the spreadsheet submitted with this document.

H. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

1. What policies, procedures, or practices of group health plans, health insurance issuers, and States may be impacted by Section 2718 of the PHS Act?

See General Comment above and the spreadsheet submitted with this document.

a. What direct or indirect costs and benefits would result?

See General Comment above and the spreadsheet submitted with this document.

b. Which stakeholders will be impacted by such benefits and costs?

See General Comment above and the spreadsheet submitted with this document.

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

See General Comment above and the spreadsheet submitted with this document.

2. Are there unique costs and benefits for small entities subject to Section 2718 of the PHS Act?

We have no information to offer at this time.

a. What special consideration, if any, is needed for these health insurance issuers or plans?

We have no information to offer at this time.

b. What costs and benefits have issuers experienced in implementing requirements relating to minimum medical loss ratio standards, reporting and rebates under State insurance laws or otherwise?

We have no information to offer at this time.

3. Are there additional paperwork burdens related to Section 2718 of the PHS Act, and, if so, what estimated hours and costs are associated with those additional burdens?

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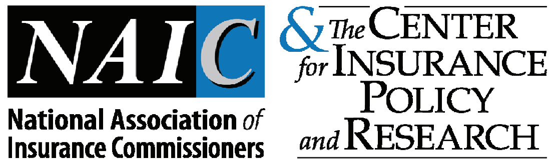

We have no information to offer at this time

These responses represent the views of the National Association of Insurance Commissioners and the data is based on surveys of state departments of insurance. The information on state regulatory activities does not include those performed by other state regulatory agencies.

Appendix A

2009 EXHIBIT ANALYSIS OF EXPENSES - 014

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	Line	Cost Containment Expenses	Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
01	Rent ($3000000 for occupancy of own building)					
02	Salaries, wages and other benefits					
03	Commissions (less $0 ceded plus $0 assumed)					
04	Legal fees and expenses					
05	Certifications and accreditation fees					
06	Auditing, actuarial and other consulting services					
07	Traveling expenses					
08	Marketing and advertising					
09	Postage, express and telephone					
10	Printing and office supplies					
11	Occupancy, depreciation and amortization					
12	Equipment					
13	Cost or depreciation of EDP equipment and software					
14	Outsourced services including EDP, claims, and other services					
15	Boards, bureaus and association fees					
16	Insurance, except on real estate					
17	Collection and bank service charges					
18	Group service and administration fees					
19	Reimbursements by uninsured plans					
20	Reimbursements from fiscal intermediaries					
21	Real estate expenses					
22	Real estate taxes					
23.1	State and local insurance taxes (taxes, licenses and fees)					
23.2	State premium taxes (taxes, licenses and fees)					
23.3	Regulatory authority licenses and fees (taxes, licenses and fees)					
23.4	Payroll taxes (taxes, licenses and fees)					
23.5	Other (excluding federal income and real estate taxes) (taxes, licenses and fees)					
24	Investment expenses not included elsewhere					
25	Aggregate write-ins for expenses					
26	Total expenses incurred					
27	Less expenses unpaid December 31, current year					
28	Add expenses unpaid December 31, prior year					
29	Amounts receivable relating to uninsured plans, prior year					
30	Amounts receivable relating to uninsured plans, current year					
31	Total expenses paid					

Appendix B

2009 A&H POLICY EXPERIENCE EXHIBIT - 210

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	Line	Premiums Earned	Incurred Claims Amount	Change in Contract Reserves	Loss Ratio	Number of Policies or Certificates as of Dec. 31	Number of Covered Lives as of Dec. 31	Member Months
A01.1	With contract reserves (individual business comprehensive major medical)							
A01.2	Without contract reserves (individual business comprehensive major medical)							
A01.3	Subtotal (individual business comprehensive major medical)							
A02.1	With contract reserves (individual business short-term medical)							
A02.2	Without contract reserves (individual business short-term medical)							
A02.3	Subtotal (individual business short-term medical)							
A03.1	With contract reserves (individual business other medical (non-comprehensive))							
A03.2	Without contract reserves (individual business other medical (non-comprehensive))							
A03.3	Subtotal (individual business other medical (non-comprehensive))							
A04.1	With contract reserves (individual business specified/named disease)							
A04.2	Without contract reserves (individual business specified/named disease)							
A04.3	Subtotal (individual business specified/named disease)							
A05.1	With contract reserves (individual business limited benefit)							
A05.2	Without contract reserves (individual business limited benefit)							
A05.3	Subtotal (individual business limited benefit)							
A06.1	With contract reserves (individual business student)							
A06.2	Without contract reserves (individual business student)							
A06.3	Subtotal (individual business student)							
A07.1	With contract reserves (individual business accident only or AD&D)							
A07.2	Without contract reserves (individual business accident only or AD&D)							
A07.3	Subtotal (individual business accident only or AD&D)							
A08.1	With contract reserves (individual business disability income - short-term)							
A08.2	Without contract reserves (individual business disability income - short-term)							
A08.3	Subtotal (individual business disability income - short-term)							
A09.1	With contract reserves (individual business disability income - long-term)							
A09.2	Without contract reserves (individual business disability income - long-term)							
A09.3	Subtotal (individual business disability income - long-term)							
A10.1	With contract reserves (individual business long-term care)							
A10.2	Without contract reserves (individual business long-term care)							
A10.3	Subtotal (individual business long-term care)							
A11.1	With contract reserves (individual business Medicare supplement (Medigap))							
A11.2	Without contract reserves (individual business Medicare supplement (Medigap))							

A11.3	Subtotal (individual business Medicare supplement (Medigap))							
A12.1	With contract reserves (individual business dental)							
A12.2	Without contract reserves (individual business dental)							
A12.3	Subtotal (individual business dental)							
A13.1	With contract reserves (individual business State Children's Health Insurance Program)							
A13.2	Without contract reserves (individual business State Children's Health Insurance Program)							
A13.3	Subtotal (individual business State Children's Health Insurance Program)							
A14.1	With contract reserves (individual business Medicare)							
A14.2	Without contract reserves (individual business Medicare)							
A14.3	Subtotal (individual business Medicare)							
A15.1	With contract reserves (individual business Medicaid)							
A15.2	Without contract reserves (individual business Medicaid)							
A15.3	Subtotal (individual business Medicaid)							
A16.1	With contract reserves (Medicare Part D - stand-alone)							
A16.2	Without contract reserves (Medicare Part D - stand-alone)							
A16.3	Subtotal (Medicare Part D - stand-alone)							
A17.1	With contract reserves (individual business - other individual business)							
A17.2	Without contract reserves (individual business - other individual business)							
A17.3	Subtotal (individual business - other individual business)							
A18.1	With contract reserves (total individual business)							
A18.2	Without contract reserves (total individual business)							
A19	Grand total individual (individual business)							
B01.1	Small employer (single employer) (group business comprehensive major medical)							
B01.2	Other Employer (single employer) (group business comprehensive major medical)							
B01.3	Single employer subtotal (single employer) (group business comprehensive major medical)							
B02	Multiple employer assns and trusts (group business comprehensive major medical)							
B03	Other associations and discretionary trusts (group business comprehensive major medical)							
B04	Other comprehensive major medical (group business comprehensive major medical)							
B05	Comprehensive/major medical subtotal (group business comprehensive major medical)							
B06	Specified/named disease (group business other medical) (non-comprehensive)							
B07	Limited benefit (group business other medical) (non-comprehensive)							
B08	Student (group business other medical) (non-comprehensive)							
B09	Accident only or AD&D (group business other medical) (non-comprehensive)							
B10	Disability income - short-term (group business other medical) (non-comprehensive)							
B11	Disability income - long-term (group business other medical) (non-comprehensive)							
B12	Long-term care (group business other medical) (non-comprehensive)							
B13	Medicare supplement (Medigap) (group business other medical) (non-comprehensive)							
B14	Federal Employees Health Benefit Plans (group business other medical) (non-comprehensive)							

B15	Tricare (group business other medical) (non-comprehensive)							
B16	Dental (group business other medical) (non-comprehensive)							
B17	Medicare							
B18	Medicare Part D - stand-alone							
B19	Other group care (group business other medical) (non-comprehensive)							
B20	Grand total group business (group business)							
C01	Credit (individual and group) (other business)							
C02	Stop loss/excess loss (other business)							
C03	Administrative Services Only (other business)							
C04	Administrative Services Contracts (other business)							
C05	Grand total other business (other business)							
D01	Total non U.S. policy forms (total business)							
D02	Grand total individual, group and other business (total business)							

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	Alabama	Alaska	Arizona	Arkansas	California	Colorado
As a starting point, please refer to the AHIP chart attached to my email. Is the information accurate for your state? ________ If not, please note corrections or additions here:	Yes (not listed; no requirements)	Yes (not listed; no requirements)	No response	No response	AHIP chart is not correct. 70% MLR applies to individual health insurance policies only. Components of the medical loss ratio are defined in Title 10, California Code of Regulations, as follows: 10 CCR 2222.11 d) The terms "premiums earned" and "losses incurred" as used in this article shall be developed by a method consistent with that method used for developing such items in Schedule H of the life and accident and health annual statement blank, unless otherwise specifically indicated in this article. (e) References to specified portions of annual statement blanks shall apply to all amendments and additions or successor provisions hereafter made. (f) "Rate revision" means a change in premium rates that applies to existing policies. (g) "Lifetime anticipated loss ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of the accumulated value of past incurred claims since the inception of the policy and the present value of future anticipated claims, and (ii) is the sum of the accumulated value of past earned premiums and the present value of future anticipated premiums earnings. (h) "Disease management expenses" means expenses incurred by an insurer for services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based guidelines and patient self-management strategies. (i) "Lifetime anticipated disease management ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of the accumulated value of past incurred disease management expenses since the inception	No. The benefits ratio percentages specified are "guidelines for the acceptability of the company's targeted loss ratio", not minimum standards. The guideline percentages are as follows: Comprehensive Major Medical (Individual) 65% Comprehensive Major Medical (Small Group) 70% Comprehensive Major Medical (Large Group) 75% Specified or Dread Disease 60% Limited Benefit Plans 60% Disability Income 60% Dental/Vision 60% Stop Loss 60% No benefit ratio guarantee is required in rate filings. The rate filing must adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period, must contain an Actuarial Memorandum and must provide the following actuarial certification: A signed and dated statement by a qualified actuary, which attests that, in the actuary's opinion, the rates are not excessive, inadequate or unfairly discriminatory.
A.1.b. To what extent do States have different minimum MLR requirements based on plan size, plan type, number of years of operation, or other factors?	No requirements	No requirements			70% loss ratio applies to all individual insurance policies that were either issued, or which underwent rate revision, after July 1, 2007. See Title 10, California Code of Regulations sec. 2222.12.	No minimum requirement. Just guidelines that vary only by type of plan (Ind MM, SG MM, LG MM, DI, etc).
B.1. What definitions and methodologies do States and other entities currently require when calculating MLR-related statistics?	No requirements	No requirements			The California Department of Insurance uses a lifetime anticipated loss ratio, as defined in Title 10, California Code of Regulations sec. 2222.11: 0 CCR 2222.11 d) The terms "premiums earned" and "losses incurred" as used in this article shall be developed by a method consistent with that method used for developing such items in Schedule H of the life and accident and health annual statement blank, unless otherwise specifically indicated in this article. (e) References to specified portions of annual statement blanks shall apply to all amendments and additions or successor provisions hereafter made. (f) "Rate revision" means a change in premium rates that applies to existing policies. (g) "Lifetime anticipated loss ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of the accumulated value of past incurred claims since the inception of the policy and the present value of future anticipated claims, and (ii) is the sum of the accumulated value of past earned premiums and the present value of future anticipated premiums earnings. (h) "Disease management expenses" means expenses incurred by an insurer for services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based guidelines and patient self-management strategies. (i) "Lifetime anticipated disease management ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of the accumulated value of past incurred disease management expenses since the inception of the policy and the present value of future anticipated disease management expenses, and (ii) is the sum of the accumulated value of past earned premiums and the present value of future anticipated premium earnings.	Below are the statutory definitions for Colorado: "Benefits ratio" means the ratio of the value of the actual benefits, not including dividends, to the value of the actual premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits ratio calculations must be displayed without the inclusion of active life reserves. "Benefits ratio" is also known as "targeted loss ratio." "Targeted loss ratio" means the ratio of the expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage to the expected earned premium over the same period. The anticipated loss ratio shall be calculated on an incurred basis as the ratio of expected incurred losses to expected earned premiums.

B.1.d. To what extent do States and other entities receive detailed information about the distribution of non-claims costs by function (for example, claims processing and marketing)? To what extent do they set standards as to which administrative overhead costs may be allocated to processing claims, or providing health improvements?	No requirements	No requirements			The California Department of Insurance does not permit administrative overhead costs to be allocated to either incurred or anticipated claims. Disease management expenses, as defined, may be included. See Title 10, California Code of Regulations, sec. 2222.11 (h): "Disease management expenses" means expenses incurred by an insurer for services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based guidelines and patient self-management strategies." The California Department of Managed Health Care uses a different regulatory approach, one that focuses on administrative expenses. See California Health & Safety Code section 1378. Administrative costs No plan shall expend for administrative costs in any fiscal year an excessive amount of the aggregate dues, fees and other periodic payments received by the plan for providing health care services to its subscribers or enrollees. The term "administrative costs," as used herein, includes costs incurred in connection with the solicitation of subscribers or enrollees for the plan. This section shall not preclude a plan from expending additional sums of money for administrative costs provid And, also: Title 28, California Code of Regulations § 1300.78 Administrative Costs (a) For the purposes of Section 1378 of the Act, "administrative costs" include only those costs, which arise ou (1) Salaries, bonuses and benefits paid or incurred with respect to the officers, directors, partners, trustees or (2) The cost of soliciting and enrolling subscribers and enrollees, including the solicitation of group contracts, a (3) The cost of receiving, processing and paying claims of providers of health care services and of claims for re (4) Legal and accounting fees and expenses. (5) The premium on the fidelity and surety bonds, and any insurance maintained pursuant to Section 1377, an (6) All costs associated with the establishment and maintenance of agreements with providers of health care s (7) The direct or pro rata portion of all expenses incurred in the operation of the plan which are not essential t (b) The administrative cost incurred by a plan, directly, as herein defined, shall be reasonable and necessary, t	Colorado does not set any standards as to administrative costs which may be allocated to processing claims or providing health improvements. Below is the definition of administrative costs in the Code of Colorado Regulations, 3 CCR 702-4, Regulation 4-2-11: "Administrative ratio" means, for purposes of this regulation, the ratio of actual total administrative expenses, not including dividends, to the value of the actual earned premiums, not reduced by dividends, over the specified period, which is typically a calendar year. Below are the annual filing requirements for health cost information in Colorado (from Section 10-16-111, Colorado Revised Statutes): (4)(a) On or before June 1 of each year, a carrier doing business in this state shall submit to the commissioner, where applicable, the following cost information for the previous calendar year: (I) Medical trend itemized by medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology; (II) Medical trend itemized by pharmaceutical price increases, utilization changes, cost shifting, and the introductions of new brand and generic drugs; (III) Dividends paid; (IV) Executive salaries, stock options, or bonuses; (V) Insurance producer commissions; (VI) Payments to legal counsel; (VII) Provision for profit and contingencies; (VIII) Administrative expenditures with breakdowns for advertising or marketing expen (IX) Expenditures for disease or case management programs or patient education and (X) Charitable contributions; (XI) Losses on investments or investment income; (XII) Reserves on hand; (XIII) The amount of surplus and the amount of surplus relative to the carrier's risk-ba (XIV) Taxes itemized by category; (XV) Administrative ratio; (XVI) Actual benefits ratio; (XVII) The number of lives insured under each benefit plan the carrier offers to small e (XVIII) The cost of providing or arranging health care services. (b) A carrier licensed in multiple jurisdictions may satisfy the requirements of paragrap
B.1.e. What kinds of criteria do States and other entities use in determining if a given company has credible experience for purposes of calculating MLR-related statistics?	No requirements	No requirements			California applies standards of actuarial practice to the evaluation of credible experience, including consideration of national experience where appropriate.	The Colorado standard for fully credible data is found in the Code of Colorado Regulations, 3 CCR 702-4, Regulation 4-2-11, and is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three years.

B.1.f. What kinds of special considerations, definitions, and methodologies do States and other entities currently use relating to calculating MLR-related statistics for newer plans, smaller plans, different types of plans or coverage?	No requirements	No requirements			Califonia has no special considerations or definitions for newer, small, or different types of coverage. However, vision-only, dental-only, or short-term limited duration health insurance with coverage durations of 6 months or less are not covered under California's individual health insurance regulation. See Title 10, California Code of Regulations sec. 2222.11(a)	No distinction for newer plans or smaller plans. Only benefits ratio guidelines that vary only by type of plan as follows: Comprehensive Major Medical (Individual) 65% Comprehensive Major Medical (Small Group) 70% Comprehensive Major Medical (Large Group) 75% Specified or Dread Disease 60% Limited Benefit Plans 60% Disability Income 60% Dental/Vision 60% Stop Loss 60%
B.2. What are the similarities and differences between the requirements in Section 2718 compared to current practices in States?	No requirements	No requirements			Sec. 2718 requires a report "concerning the ratio of incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums." Section 2718 anticipates that total premium revenue, after adjustments, will be compared to (1) clinical services, (2) "activities that improve health care quality", and (3) "all other non-claims costs", excluding taxes and fees. Further, Section 2718(b) provides that factors (1) and (2), above, will be compared to premium revenue, net of taxes and fees. California uses a narrower definition than "activities that improve health care quality." California uses "disease management expenses," defined as "services administered to patients" (Title 10, California Code of Regulations sec. 2222.11(h)). The California definition therefore does not include quality-improvement measures that are not services directly provided to patients.	Quality related expenses are not included in definition of benefits ratio. No rebate required. Colorado requires insurers to submit annual report regarding health insurance costs (see answer to question 1d above). Colorado does not allow Federal and state taxes and fees, reinsurance and risk adjustment payments to be deducted from the earned premium.
B.2.b. What MLR-related data elements that are required by PPACA do States or other entities currently require issuers to submit, and how are they defined? What elements are not currently submitted?	No requirements	No requirements			Please see above response.	Please see answers to question 1 above.

B.3. What definitions currently exist for identifying and defining activities that improve health care quality?	No requirements	No requirements			California uses "disease management expenses," defined as "services administered to patients" (Title 10, California Code of Regulations sec. 2222.11(h)). The California definition tdoes not encompass quality-improvement measures that are not services directly provided to patients.	None in Colorado law
B.3.a. What criteria do States and other entities currently use in identifying activities that improve health care quality?	No requirements	No requirements			Title 10, California Code of Regulations, as follows: 10 CCR 2222.11 (h) "Disease management expenses" means expenses incurred by an insurer for services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based guidelines and patient self-management strategies.	None in Colorado law
B.3.b. What, if any, lists of activities that improve health care quality currently exist?	No requirements	No requirements			Title 10, California Code of Regulations, as follows: 10 CCR 2222.11 (h) "Disease management expenses" means expenses incurred by an insurer for services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based guidelines and patient self-management strategies.	None in Colorado law
B.3.c. To what extent do current calculations of medical loss ratios include the amount spent on improving health care quality? Is there any data available relating to how much this amount is?	No requirements	No requirements			The definition appears below. California does not have aggregated data regarding this amount. Title 10, California Code of Regulations, as follows: 10 CCR 2222.11 (h) "Disease management expenses" means expenses incurred by an insurer for services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based guidelines and patient self-management strategies.	Quality related expenses are not included in definition of benefits ratio

D.1. To what extent do States or other entities currently require annual submission of actual medical loss ratio-related statistics for the individual, small group, and large group markets?	No requirements	No requirements			California requires an annual certification that the lifetime anticipated loss ratio standard is met for each policy form. See Title 10, California Code of Regulations 2222.19.	Please see answer to question 1d above.
D.2. How soon after the end of the plan year do States and other entities typically require issuers to submit the required MLR-related statistics?	No requirements	No requirements			By April 1, or upon submission of a rate increase. California insurance companies regulated by the Department of Insurance are not restricted to a particular plan year, and many renew their policies monthly. Many California managed care companies regulated by the Department of Managed Health Care are on a January 1 calendar year plan year basis.	Due on June 1

D.3. What kinds of supporting documentation are necessary for interpreting these kinds of statistics? What data elements and format are typically used for submitting this information?	No requirements	No requirements			California requests the following information be provided with rate submissions, in excel spreadsheet format: 1) Date policy first issued 2) Is block of business open or closed? 3) If closed, date last policy was issued. 4) Policyholder count, state & national, most recent 5) Policyholder count, state & national, annually over most recent 10 years, or since first issued. 6) Average duration, in years, state & national, annually over most recent 10 years, or since first issued. 7) Realized historical loss ratio, by calendar year & duration, excluding Active Lives Reserves, state & national. 8) Total realized historical loss ratio for all durations and excluding changes in Active Lives Reserves, state & national. 9) Anticipated Future Loss Ratio, by duration, excluding Active Lives Reserves, of the block of business, for the next 10 years, state and national. 10) Realized (accumulated) historical loss ratio for this block of business, state & nationa. 11) Anticipated (discounted) future loss ratio for this block of business. 12) Anticipated lifetime loss ratio for this block of business. 13) Implementation date of last rate increase in California 14) List the rate increases implemented in California each year, over the previous ten years, or since the year when the product was first marketed if the product has been marketed for less than ten years. 15) List the weighted average of rate increases implemented nationwide, excluding California, over the previous ten years, or since the date when the product was first marketed if the product has been marketed for less than ten years [Earned premium dollars in each state should be used as weights]. 16) Annual lapse rate for the past ten years – percentage of policyholders as of 1/1/xxxx that had lapsed by 12/31 of the same year, state and national. 17) The main justifications for rate increase request: Inflation, utilization increases, changing technology/ application of newer forms of treatment, revision of geographic factors that are not revenue neutral, changing competitive environment, revision of original assumptions used for development of rates, adverse – actuarially credible – experience, other (please explain). 18) The amount of rate increases applied for, concurrently with the present rate increase, in other states, and whether the rate increases have been approved/ authorized/ acknowledged, or pending approval/ authorization/acknowledgement. Provide a weighted average.	Many elements of the health cost report are similar to line items on the statutory annual statement. Annual health cost information must be submitted using Excel worksheets.

D.5. To what extent is MLR-related information submitted to States or other entities currently made available to the public, and how is it made available (for example, level of aggregation, and mechanism for public reporting)?	No requirements	No requirements			Rates are available to the public, upon appointment, at the San Francisco office of the Department of Insurance after the rates are acknowledged. Actuarial memoranda and other supporting actuarial data generally are not made public, although the Commissioner retains discretion to make them public.	Aggregated health cost information is made available to the public via the Division of Insurance website. The report on health costs and the report on the factors that drive health costs are published on the Division of Insurance website.

E.1. To what extent do States and other entities currently require MLR-related rebates for the individual, small group, large group, and/or other insurance markets, and how are these rebates calculated and distributed?	No requirements	No requirements			California does not require rebates.	No rebate required in Colorado.
E.2. How soon after the end of the plan year do States and other entities currently require issuers to determine if rebates are owed?	No requirements	No requirements			Not applicable.	N/A
E.4. How do States and other entities currently determine which enrollees should receive medical loss ratio-related rebates?[1]	No requirements	No requirements			Not applicable.	N/A

E.5. What method(s) do States and other entities currently require issuers to use when notifying enrollees if rebates are owed, and paying the rebates?	No requirements	No requirements			Not applicable.	N/A
G.1. What methods do States and other entities currently use in enforcing medical loss ratio-related requirements for the individual, small group, large group, and other insurance markets (for example, oversight and audit requirements)?	No requirements	No requirements			In the California insurance market, only individual health insurance policies are subject to loss ratio regulation. Rate increase requests are evaluated for loss ratio compliance upon submission. Forms whose rates are out of compliance with the loss ratio regulation are subject to withdrawal, after a hearing. California Insurance Code sec. 10293.	Requested rate increases are subject to prior approval by the Division (Section 10-16-107(1), Colorado Revised Statues). Pursuant to Section 10-16-107(1.6)(a), C.R.S., the commissioner shall disapprove the requested rate increase if any of the following apply: (I) The benefits provided are not reasonable in relation to the premiums charged; (II) The requested rate increase contains a provision or provisions that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of statute; (III) The requested rate increase is excessive or inadequate. In determining if the rate is excessive or inadequate, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve and reserve for losses, surpluses, executive salaries, expected benefits ratios, any factors required to be submitted as part of the annual health cost information report in Section 10-16-111, and any other appropriate actuarial factors as determined by current actuarial standard (IV) The actuarial reasons and data based upon Colorado claims experience and data, (V) The rate filing is incomplete. Pursuant to Section 10-16-107(1.6)(b), C.R.S., in determining whether to approve or d

G.2. What, if any, penalties do these entities currently apply relating to noncompliance with medical loss ratio-related requirements? What, if any, related appeals processes are currently available to issuers?	No requirements	No requirements			Forms whose rates are out of compliance with the loss ratio regulation are subject to withdrawal, after a hearing. California Insurance Code sec. 10293	After public hearing if rate is found to be excessive or unfairly discriminatory, Commissioner may issue an order and require excess premium plus 8% to be refunded to policyholder. In addition to other remedies or penalties provided by law, Commissioner may suspend or revoke insurer's certificate of authority. Any finding shall be subject to judicial review by the court of appeals (see Section 10-16-216.5, Colorado Revised Statutes). Commissioner may order an insurer to pay restitution under Section 10-3-105(4)(a), C.R.S.
H.1. What policies, procedures, or practices of group health plans, health insurance issuers, and States may be impacted by Section 2718 of the PHS Act?					It would be premature for California to estimate the impact at this time without further clarification and guidance in regards to the provisions of Section 2718.	Colorado feels that it would be premature to estimate the impact at this time without further clarification and guidance in regards to the provisions of Section 2718.

H.1.a. What direct or indirect costs and benefits would result?					It would be premature for California to estimate the impact at this time without further clarification and guidance in regards to the provisions of Section 2718.	
H.1.b. Which stakeholders will be impacted by such benefits and costs?					It would be premature for California to estimate the impact at this time without further clarification and guidance in regards to the provisions of Section 2718.	
H.1.c. Are these impacts likely to vary by insurance market, plan type, or geographic area?					It would be premature for California to estimate the impact at this time without further clarification and guidance in regards to the provisions of Section 2718.	

[1] For example: current policyholders, current policyholders who were enrolled in the coverage during the applicable time period, or all policyholders who were enrolled in the coverage during the applicable time period (regardless of whether they are still active policyholders).

Connecticut	Delaware	D.C.	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana
No. The definition of medical loss ratio for managed care organizations is medical loss ratio or percentage of the total premium revenues spent on medical care compared to administrative costs and plan marketing. The language "and how it compensates health care providers at its premium level" is not part of the definition of the medical loss ratio. Under Individual, it is incorrect that a loss ratio guarantee is required in premium rate filings. The loss ratio guarantee may be filed at the option of the carrier in lieu of a standard rate filing and is subject to refund requirements if the loss ratio is not met.	No response	No response	No response	No response	Yes (not listed; no requirements)	No response	Yes (not listed; no requirements)	No response	No. The chart references §§191-36.09(2), however, it should be 191-36.9(2)	Yes	No response	No response
AHIP chart correctly reflects there are no minimum loss ratio requirements except for the special health care plans in the small employer market.					No requirements		No requirements		Iowa has the 1980s vintage NAIC model and the loss ratios are correctly referenced in the AHIP chart @Iowa Administrative Cod e 191-36.10.	The chart provided outlines the different MLR requirements for low annual premium individual plans in Kansas and the lack of MLR requirements for group coverage.		
Ratio of incurred claims to earned premiums.					No requirements		No requirements		To the best of my knowledge, Iowa considers incurred claims to be 'paid claims' + change in claim reserves (reserve for incurred but unpaid claims). So in Iowa, the traditional definition of the MLR is incurred claims divided by earned premiums.	Ratio of incurred claims to earned premiums.		

This varies by carrier as there are not specific requirements.					No requirements		No requirements		In Iowa – we do not receive or require such reports, nor do we set standards.	There are not specific requirements for such reporting in Kansas.		
State specific credibility can be determined using total member months, earned premium or total number of claims, much of which may be determined by the carriers rate manual filed with the state as there is nothing statute specific. Nationwide experience would be considered if experience was not credible, as well as experience on similar products.					No requirements		No requirements		This can be a contentious issue in the rate filing process. Iowa has not adopted any credibility standards, so we try to determine (on a case-by-case basis) if Iowa experience (and the resulting MLR) can stand on its own. If it can't, then we would either weight it with the U.S. block, or completely ignore it. One of the ways we gauge credibility is to graph the stream of pure premiums and/or On-Level loss ratios (with the premiums restated to the current rate level). If the graph appears to be smooth along with a corresponding high correlation coefficient (>=.90), we would likely utilize Iowa experience in some fashion in our review.	State specific credibility can be determined using total member months, earned premium or total number of claims, much of which may be determined by the carriers rate manual filed with the state as there is nothing statute specific. Nationwide experience would be considered if experience was not credible, as well as experience on similar products.		

There is recognition for closed blocks of business versus open blocks of business, since the closed blocks are no longer incurring up front acquisition expenses, but again there is nothing statute specific.					No requirements		No requirements		Speaking strictly about the rate revision process, Iowa frequently requests an actual to expected demonstration via a special template called Exhibit 2. This template assists the Division in assessing how the current experience compares to what was anticipated using original pricing assumptions. In the early years of a plan, the 'expected loss ratio' can be lower than what is required by law, and in the later years, the 'expected loss ratio' will likely be significantly higher than what is required by law.	There are no stautory requirements for special considerations given to newer plans versus older plans when calculating MLR.		
All non-claims costs are treated as expenses and cannot be included with incurred claims. Adding these expenses to incurred claims for purposes of calculating the actual loss ratio, results in a carrier meeting the statutory MLR more easily. In Connecticut, using claims alone, a carrier would be held to a higher standard.					No requirements		No requirements			All non-claims costs are treated as expenses and cannot be included with incurred claims. Adding these expenses to incurred claims for purposes of calculating the actual loss ratio, results in a carrier meeting the statutory MLR more easily. In Kansas, using claims alone, a carrier would be held to a higher standard.		
As previously discussed all non-claim costs are treated as expenses and cannot be included with incurred claims for purposes of the MLR calculation.					No requirements		No requirements		Iowa simply defines the MLR as [(paid claims + change in IBU) / earned premium] so it includes no adjustment for spending on activities that improve health care quality.	As previously discussed all non-claim costs are treated as expenses and should not be included with incurred claims for purposes of the MLR calculation.		

Nothing specific required.					No requirements		No requirements		With regard to the rate review process in Iowa – none that I am aware of.	No stautory definitions or requirements.		
Not currently required					No requirements		No requirements		In Iowa – we do not receive or require such reports, nor do we set standards.	No stautory requirements.		
The Department has no such list.					No requirements		No requirements		NA with respect to the rate review process and the MLR	Kansas has no such list.		
In CT, any such expenses would be included in the earned premiums and not reflected as an addition to incurred claims.					No requirements		No requirements		NA with respect to the rate review process and the MLR	This amount would not be included in incurred claims for a MLR calculation in Kansas.		

This type of information would be included in any rate filing. Filings are required for individual products and group products, both small and large, offered by health care centers (HMOs). Loss ratios are part of the annual reports for managed care organizations.					No requirements		No requirements		NA	This information is included in all premium rate filings. In addition, it is included in some annual reports. Rate filings are not required to be filed annually, but carriers do file at least annually to maintain adequate premium rates.		
Rate filings have no required date. The MLR-related statistics are not provided for each group policyholder and since plan years for each group policyholder can vary the MLR statistics are provided through rate filings that are submitted at least once per year by each carrier. The annual reports for managed care organizations are required each May 1.					No requirements		No requirements		NA for Iowa – Iowa only receives the experience and MLRs at the time of a rate change request.	Rate filings do not have a required filing date.		

We ask for an actual-to-expected analysis of prior experience that includes incurred claims, earned premium and the resulting MLR. Even if the carrier is meeting a predefined MLR doesn't mean that they can't price to a higher MLR. This information is provided by calendar year from inception of the product to the most up-to-date period.					No requirements		No requirements		NA	Kansas requires a calendar year analysis of MLR calculations beginning from inception of sales. In addition, a projection of at least five years is required and all assumptions used in the projection.				

There is an annual report card published, on our website and also available in print, for managed care organizations that includes the loss ratio. Rate filings are subject to public inspection although carriers may currently request that trade secret information be held confidential.					No requirements		No requirements		Effective with its enactment on April 9, 2010, a bill passed this spring and signed by the Governor changed some of Iowa's reporting requirements for what is made available to the public changed at least in terms of the automatic disclosure of information that may have been submitted to the Division but would have only been available to the public upon request. Specifically, a section intended to increase transparency regarding costs that contribute to rate increases stipulated the following: The commissioner in collaboration with the consumer advocate shall prepare and deliver a report to the governor and to the general assembly no later than November 15 of each year that provides findings regarding health spending costs for health insurance plans in the state for the previous fiscal year. The commissioner may contract with outside vendors or entities to assist in providing the information contained in the annual report. The report shall provide, at a minimum, the following information: a. Aggregate health insurance data concerning loss ratios of health insurance car b. Rate increase data. c. Health care expenditures in the state and d. A ranking and quantification of those fact e. The current capital and surplus and reser f. A listing of any apparent medical trends a g. Any additional data or analysis deemed a h. Recommendations made by the work gro	All premium rate filings are available for public viewing. An open records request must be completed and any costs associated must be paid by the requestor.		

In the individual market, carriers may opt to file a loss ratio guarantee (Connecticut General Statute 38a-481(e). The rates are deemed approved, but refunds are required if the loss ratio guarantee is not met. Only one carrier currently files in this manner. An independent accounting firm generates the loss ratio guarantee analysis which is filed with the State annually. If any rebate is necessary, the carrier either provides a credit on future premiums or sends the individual the rebate directly.					No requirements		No requirements		NA	Medicare supplement refund calculations are required to be submitted each year by any carrier that has business in Kansas.		
State law requires that the loss ratio guarantee audit shall be performed in the second quarter following the plan year and submitted to the State no later than June 30th.					No requirements		No requirements		NA	Medicare supplement refund calculations are required to be submitted by May 31.		
The State requires that the refund be made to all Connecticut policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal two dollars or more.					No requirements		No requirements		NA	On a statewide basis as adopted in the NAIC Medicare supplement model regulation.		

A guarantee that the actual Connecticut or nation-wide loss ratio results, as the case may be, for the experience period at issue will be independently audited by a certified public accountant or a member of the American Academy of Actuaries at the insurer's expense. The audit shall be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Insurance Commissioner not later than June thirtieth following the end of the experience period Payment shall be made during the third quarter of the year following the experience period for which a refund is determined to be due.					No requirements		No requirements		NA	Refunds must be made with interest by September 30th.		
Connecticut does not have statutory MLR requirements for these markets, except for the loss ratio guarantee option available to individual carriers. The audit report for the loss ratio guarantee is reviewed by a staff actuary.					No requirements		No requirements		With regard to the rate revision process, Iowa is a pre-approval state, so we have kind of a 'back-door' way of enforcing the MLR standard.	Actuarial certification must include that minimum loss ratio required by K.A.R. 40-4-1 must be met prior to sale in Kansas for individual coverage. In addition, audits of loss experience are made at the time of subsequent rate filings to determine compliance. There are not MLR requirements for group coverage in Kansas.		

Not applicable.					No requirements		No requirements		NA	Upon finding that a carrier does not meet or exceed the required MLR compensation must be provided to the policyholder in the form of a refund, credit, or reduced premium.		

Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire
No. Under "Relevant Definitions," it should cite the definition of "loss ratio" in Rule 940, section 4(D): D. "Loss ratio" means the ratio of incurred claims to earned premiums for a given period, as determined in accordance with accepted actuarial principles and practices. For the purposes of this calculation, incurred claims do not include any claim adjustment expenses or cost containment expenses except that any savings offset payments paid pursuant to section 24-A M.R.S.A. §6913 must be treated as incurred claims. I further note that this is a little out of date due to changes in statute, and we plan to amend the rule. However, even without amendment of the rule, the statute takes precedence. Specifically, 24-A M.R.S.A. § 6913 referred to in the definition has been repealed and replaced by 24-A M.R.S.A. § 6917. This replaces the "savings offset payment" with an "access payment." While not specified in the new statute as it was in the prior one, our interpretation is that the payments are included in the numerator of the loss ratio.	Yes	No response	No response	No. For all HMOs, for Blue Cross, and for insurance companies assessed more than 3% of the market for the state high risk pool, the MLR is 72% for individual and 82% for small group. For insurance companies assessed less than 3% of the market for the state high risk pool, the MLR is 60% for individual and also for small group. The numerator includes claims, cost containment expenses (generally these are less than 1% of premiums), and any taxes added after 1992.	No response	Yes (not listed; no requirements)	Yes (not listed; no requirements)	No response	Yes (No requirements)	For the most part. One key feature for small group health insurance not mentioned is the concept that if your prior year's rate exceeded what you projected you would need…. Then any excess has to be considered (an offset to required revenue) in current year filing.
No variation.	MD Minimum Loss Ratios: Individual - 60%, Small Group - 75%			No variation in the MLR requirements by those factors.		No requirements	No requirements		N/A	See AHIP chart
Rule 940, section 4(D): D. "Loss ratio" means the ratio of incurred claims to earned premiums for a given period, as determined in accordance with accepted actuarial principles and practices. For the purposes of this calculation, incurred claims do not include any claim adjustment expenses or cost containment expenses except that any savings offset payments paid pursuant to section 24-A M.R.S.A. §6913 must be treated as incurred claims. I note that this is a little out of date due to changes in statute, and we plan to amend the rule. However, even without amendment of the rule, the statute takes precedence. Specifically, 24-A M.R.S.A. § 6913 referred to in the definition has been repealed and replaced by 24-A M.R.S.A. § 6917. This replaces the "savings offset payment" with an "access payment." While not specified in the new statute as it was in the prior one, our interpretation is that the payments are included in the numerator of the loss ratio.	MIA defines the loss ratio as the ratio of incurred claims to earned premiums			Loss adjustment expenses are not included in the LR. They typically are in the range of one to five percent of premium. Loss ratios are calculated for the period that the filed rates will be in effect, using historical experience as a basis for projecting future loss ratios. For major medical, usually rates are filed once per year, sometimes with monthly or quarterly trend factors for different effective dates within the year. Historical loss ratios are calculated on an accident-year basis, not a calendar-year basis. In other words, the most current information available is used to restate historical premiums and claims. Any corrections are posted to the proper prior period, not used to adjust the current period as is done in the financial statements for accounting purposes. Contract reserves generally do not exist in Minnesota for major medical insurance.		No requirements	No requirements		N/A	

Maine requires an annual report showing data for several categories of administrative expense as well as claims, premiums, and enrollment, divided into individual, small group, and large group. Claims adjustment expenses are divided into Cost containment expenses and other. Quality improvement expenses are not split out. The requirements are in Rule 945.	Carriers selling Health Benefit Plans are required to report to the MIA incurred expenses, which includes commissions, acquisitions costs, general expenses, taxes, licenses, and fees.			Minnesota does not request information about non-claims costs, except for cost containment expenses. For cost containment expenses, overhead may be allocated using any reasonable method.		No requirements	No requirements		N/A	
All companies must report regardless of credibility. For purposes of the optional guaranteed loss ratio option for small group carriers, which requires refunds if the loss ratio is not met (as described in section E below), only those with 1,000 or more covered lives are eligible.	All carriers selling Health Benefit Plans are required to report to the MIA loss ratio information, regardless of size. MD does not have specific rules for credibility, but will consider credibility with appropriate justification when examining an issuer's reported loss ratio.			Minnesota has no specific rules, but will ask for actuarial support for a company's position on the relative credibility of their historical loss ratios.		No requirements	No requirements		N/A	

None.	None.			Minnesota allows recognition of the durational slope of claims for major medical business. Even in non-underwritten small group business, there is a clear upward slope by duration for the first year or two. In individual business, there is a very steep upward slope for the first five to fifteen years. For the first year of coverage in underwritten individual business, it is not uncommon to have a 40% loss ratio that rises to an 80% loss ratio at the same rate level when an average mix of durations is eventually reached. Minnesota also allows the pooling of catastrophic claims in order to get higher credibility on historical experience. For example, all claims on one person in one year that exceed $200,000 may be removed from every category of historical claim experience, and a percentage added back in to all categories to adjust for the removals. As noted in the comments at the top, we have a much lower MLR only for insurance companies that do not have a large share of the MN market. I think this was intended to stimulate competition and encourage new carriers to enter the market.		No requirements	No requirements		N/A	
Maine includes only incurred claims and the Dirigo access payment in the numerator, not quality expenses or claims adjustment expenses. All earned premiums are included in the denominator with no reduction for taxes or fees. Reporting is by calendar year, not "plan year."	The MIA only considers incurred claims in the numerator of the LR, and does not adjust earned premiums in the denominator of the LR			Minnesota does not include loss adjustment expenses in the numerator. Minnesota does not adjust premiums for any reinsurance. Minnesota does not include quality improvement expenses in the numerator. Minnesota does include cost containment expenses in the numerator.		No requirements	No requirements		N/A	
Incurred claims and earned premiums are reported in the rule 945 report described in B.1.d above, as are state taxes and fees. Federal income tax is not reported split by market.	MIA requires issuers to submit Incurred claims and earned premiums. MIA also requires issuers to submit expenses, but not in the detailed splits that PPACA requires.			Minnesota requires each calendar year's aggregate premiums, claims, and cost containment expenses to be reported separately for the individual and small group market. Only carriers with at least 100,000 dollars of annual premium in Minnesota must report. Carriers that issue only conversion policies mandated by state law for persons leaving group coverage do not have to report in the individual medical market.		No requirements	No requirements		N/A	

None.	MIA currently does not require reporting on activities that improve health care quality.			Minnesota may have some activity by our Health Department. We don't do this in the Insurance Division.		No requirements	No requirements		None	
None.	MIA currently does not require reporting on activities that improve health care quality.			Minnesota may have some activity by our Health Department. We don't do this in the Insurance Division.		No requirements	No requirements		N/A	
We are not aware of any.	MIA currently does not require reporting on activities that improve health care quality.			Minnesota may have some activity by our Health Department. We don't do this in the Insurance Division.		No requirements	No requirements			
These expenses are not included. We have no data.	MIA does not include amounts spent on improving health care quality in the LR.			Not at all, unless it is included in claims or cost containment expenses.		No requirements	No requirements		N/A	

The Rule 945 report described in B.1.d above includes all of the elements of the loss ratio as defined in Maine.	MIA requires all issuers of Health Benefit Plans report to loss ratio information annually. This is for all markets, which includes individual, small group, and large group.			Minnesota requires this for individual and small group, but not for large group.		No requirements	No requirements		N/A	
The Rule 945 report described in B.1.d above is due March 1, although extensions may be granted. The reports used to calculate small group refunds under the guaranteed loss ratio option described in section E below are due February 1 for the 12 months ending June 30 of the prior year. The delay is because six months of claims runout are required. The non-calendar year is used because the requirement took effect mid-year (2004).	MIA requires issuers of Health Benefit Plans to report loss ratio information by March 31 following the end of the preceding reporting year.			Minnesota requires the information in aggregate by May 1 for the previous calendar year.		No requirements	No requirements		N/A	

Maine requires the report used to calculate small group refunds (described in section E below) to include documentation of how the unpaid claims estimate was determined, although it is not a majot factor due to the six months of claims runout included.	None. The information is submitted on a standardized PDF form.			None.		No requirements	No requirements		N/A	

The Rule 945 reports described in B.1.d above are publicly available and those for the major carriers are posted on our website. In addition, summary reports showing loss ratios and other ratios are posted. For the summaries, results are combined for related companies.	Available on the MIA website, aggregated by issuer.			Available on our website aggregated by individual vs. small group for each insurer.		No requirements	No requirements		N/A	

In the small group market, carriers that cover at least 1,000 lives can choose between filing rates for prior approval and demonstrating a 75% anticipated loss ratio or filing rates with no approval necessary and guaranteeing a 78% loss ratio. All of the major carriers choose the second option, which requires refunds if the loss ratio is not met over a rolling three-year period. The refund calculation, set forth in Rule 940, Section 9(E) and Appendix B, essentially determines the amount of premium that would have resulted in a 78% loss ratio and requires the actual premium in excess of this amount to be refunded. Refunds are distributed on a pro rata basis (based on premium) to the entities or persons that paid the premium. However, in most cases, employers collect employee contributions through payroll deduction and pay the entire premium to the insurer. In these cases the entire refund is paid to the employer. We encourage employers to share the refund with employees in proportion to their contribution, but we cannot require this due to ERISA preemption.	MIA does not have authority to require rebates, the Insurance Commissioner has authority to order an individual or small group issuer to reduce their rates if issuer's actual loss ration does not exceed the minimum loss ratio for the appropriate market.			Minnesota does not have rebates.		No requirements	No requirements		N/A	RSA 415:24 is the loss ratio guarantee provision. A carrier can file a loss ratio guarantee with the State. By guaranteeing the loss ratio, rates are deemed approved. If the LR isn't met, the carrier has to make premium refunds.
Reporting is for the 12 months ending June 30, not by plan year. The off-calendar year cycle is because the requirement took effect mid-year. The report is due February 1 to allow six mpnths of claims runout and one month to produce the report.	MD does not require rebates.			Minnesota does not have rebates.		No requirements	No requirements		N/A	
Refunds must be paid only to holders of policies that are still in force as of the date the refunds are calculated. The percentage of premium refunded is increased to account for those no longer in force.	MD does not require rebates.			Minnesota does not have rebates.		No requirements	No requirements		N/A	

Refunds must be paid by March 1, one month after the reporting date.	MD does not require rebates.			Minnesota does not have rebates.		No requirements	No requirements		N/A	
Rates for individual are subject to prior approval. Targeted exams may be if used reported data looks questionable.	The Insurance Commissioner has authority to order an individual or small group issuer to reduce their rates if issuer's actual loss ration does not exceed the minimum loss ratio for the appropriate market.			Minnesota compares rate filing historical information to the information reported in the NAIC annual statement, which is audited. Minnesota requires a qualified actuary to prepare a memorandum to accompany each rate filing. Minnesota does not approve an annual rate filing until loss ratio compliance has been demonstrated.		No requirements	No requirements		N/A	

In one case where a carrier was found to be reporting loss ratios on an inappropriate basis in rate filings, refunds of $4.6 million were required to be paid to policyholders and the company paid a $1 million fine. Insurers are entitled to a hearing and can appeal the decision to the courts.	The Insurance Commissioner has authority to order an individual or small group issuer to reduce their rates if issuer's actual loss ration does not exceed the minimum loss ratio for the appropriate market. Issuers may request a hearing to appeal the order to reduce premium rates.			Minnesota notifies issuers of their right to appeal rate disapproval and have a hearing before an administrative law judge.		No requirements	No requirements		N/A	
Maine will need to amend its laws and rules.	The governor of Maryland has formed the Health Care Reform Coordinating Council to determine what changes Maryland need to make to impacted state agencies, state laws and regulations, and policies and practices. The Council is currently conducting a comprehensive review of the state level changes that will be required. Part of this review will include the impacts of Section 2718.			Minnesota does not currently have any information to provide regarding the cost or impact to us of Section 2718.						

Not known at this time.	The Maryland Health Care Reform Coordinating Council is conducting a comprehensive review of state level changes and will provide their estimate of the impact of, and the costs and benefits of Section 2718.			Minnesota does not currently have any information to provide regarding the cost or impact to us of Section 2718.						
Not known at this time.	The Maryland Health Care Reform Coordinating Council is conducting a comprehensive review of state level changes and will provide their estimate of the impact of, and the costs and benefits of Section 2718.			Minnesota does not currently have any information to provide regarding the cost or impact to us of Section 2718.						
Not known at this time.	The Maryland Health Care Reform Coordinating Council is conducting a comprehensive review of state level changes and will provide their estimate of the impact of, and the costs and benefits of Section 2718.			Minnesota does not currently have any information to provide regarding the cost or impact to us of Section 2718.						

New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island
Yes.	Yes.	No response	Yes. However, for non-group policies, companies may file standards greater than the NAIC minimums and not-for-profit BCBSNC plan is held to their allowable loss ratio standard which for 2010 was 82.6%.	Yes	Yes	Yes	Somewhat. p. 3, line 15: "individual and small group markets" p. 24, line 16, column "Applicability": "Individual, small group, associations & trusts, and large group"	No response	No response
NJ does not have a minimum MLR for large group. The minimum MLR for individual and small group (2-50 employees) is 80%, and there is no variation in this 80% minimum MLR for any factor. (The minimum MLR for individual and small group was 75% for years 2008 and prior).	NM MLR Law becomes effective 5/19/2010, but will not require dividends until three years of data are accrued to determine if minimum is met. Individual minimum was set at 75% instead of 80%, but the Superintendent of Insurance is required to review it.		Different for HMO versus non-HMO. For non-group, we also apply the NAIC high/low average annual premium adjustment. No other variations.		There is no variation on the MLR requirements based on factors.	No statutory provision.	N/A		
Claims are amounts paid to providers for covered medical care to covered people. Incurred claims are calculated as paid claims, adjusted for six months of claims run-out and a formula or other residual reserve. Premiums are earned premiums (without adjustment for refunds attributable to prior years.) Claims are not permitted to include amounts spent for health improvement, quality control, or cost containment, regardless of whether these are considered to be positive activities or whether the person performing the activities are licensed medical professionals. On the other hand, amounts paid to integrated providers of services (such as behavioral health or imaging) are counted entirely as claims, even though these integrated providers usually perform (and are being compensated for) other than clinical services such as pre-authorization.	As defined in law, Premium taxes and assessments (high risk pool and alliance pool) will be deductible from Earned Premiums, making the minimum loss ratios about 4% less than standard calculations in NM.		Use incurred claims divided by earned premium. Follow NAIC statutory annual statement instruction definitions. Non-claims related expenses and cost containment expenses are excluded from incurred claims.		This is defined in the AHIP chart.	36 OS 6515A2 - A small employer health benefit plan shall not be delivered or issued for delivery unless the policy form or certificate form can be expected to return to policyholders and certificate holders in the form of aggregate benefits provided under the policy form or certificate form at least sixty percent (60%) of the aggregate amount of premiums earned. The rate of return shall be estimated for the entire period for which rates are computed to provide coverage. The rate of return shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period in accordance with accepted actuarial principles and practices;	It's driven by the annual statement's exhibit of premiums, enrollment, & utilization.		

This information is not reported through the MLR report process (which has only premiums and claims). It is reported in the informational rate filing process for small employer (where it is confidential) and individual (where it is public). Other than the minimum loss ratio requirement of 80% which sets an aggregate standard 20% for administrative expenses (including health improvement) and underwriting gain, there are no requirements for any components.	NM put a regulation into effect 09/01/09 requiring companies to provide the information on loss ratios each year by April 15th. Unfortunately, the included definition of loss ratio was flawed and I was not able to get it changed before publication.		Only to the extent collected in the annual statement. Not typically reviewed in rate filings at this time.		There is no additional reporting other than what is answered in AHIP chart.	No statutory basis	We have only begun to collect this in rate filings. We use the same definitions as #1.		
NJ does not apply a credibility standard, and so the MLR requirements are applied even for carriers with very small enrollment. There have been instances where a carrier with very low enrollment has paid refunds that would not have been paid if a credibility standard (or a rule for aggregating experience over multiple years) had been in effect.	NM uses the Medicare Supplement Model Law table (full credibility at 10,000 life years experience from inception down to zero credibility for less than 500 life years).		This may be based upon the number of years of experience data, counts of the number of incurred claims or policy year exposure counts. Typically a standard for full credibility is determined using limited fluctuation approach (see Chapter 5, Introduction to Credibility Theory, Thomas Herzog). Partial credibility normally uses the square root formula.		As this is the first year this reporting was required, this is reviewed on a case by case basis. Other information such as prior year data may be taken into account.	No statutory basis	None yet.		

NJ does not make any such adjustments	NM has used the NAIC Model Law Guidelines #134 as a Standard up to now.		Recognition is given durational factors.		None	No statutory basis	None yet.		
In calculating the loss ratio, NJ limits the numerator to claims paid for clinical services without adding health improvement or cost containment expenses. NJ places the entire premium in the denominator, without reduction for Federal and state taxes.	NM rewrote its rules last year as follows: NMAC 13.10.13 Managed Health Care--Basic Benefits 13.10.21 HMO requirements 13.10.22 Plan Compliance 13.10.23 Contracting There is too much material to do a comparative analysis this week.		North Carolina does not include loss adjustment expenses or quality improvement expenses in the numerator and does not currently subtract out taxes and regulatory fees from the denominator.		Differences- We allow for commissions, managed care, and fraud costs to be excluded from administrative expense. Similarities – Claims and Premium are exclusive of reinsurance.	Oklahoma does not collect statistics for health care quality or require rebates. Oklahoma relies upon the actuarial memorandum in support of the medical loss ratio.	We don't consider risk adjustment and risk corridors and payments of reinsurance, and we don't separate quality improvement costs.		
NJ requires submission of premiums and claims. It does not require submission of components of underwriting expenses or gains in the MLR reports. (It does require such detail in informational rate filings, but that is anticipated, not actual, data.)	NM simplified the report requirements this year, but will be ready next year. I thought that the Supplemental forms 8, 9, 10, & 11 for Health Cos and 56, 57, 58, and 59 for Life, ACC & Health provided most of the answers needed.		Incurred claims, earned premium and change in contract reserves if applicable are currently submitted.		See above or refer to AHIP chart.	Small group: Incurred claims and premium volume are required.	We require claims costs and admin costs as described above.		

NJ does not currently define this.	Defined in 13.10.21.7: F. "Quality assurance plan" means the internal ongoing quality assurance program of an HMO to monitor and evaluate the HMO's health care services, including its system for credentialing health professionals applying to become a participating provider with an HMO or otherwise providing services to the HMO's covered persons.		Not currently in use.		None	None	None yet.		
NJ does not currently define this.	In development.		Not currently in use.		None	None	None yet.		
NJ does not currently define this.	Some in NM outpatient rules		The Managed Health Care Handbook by Peter Kongstvedt has some good information. This reference may provide greater detail to fill in detail to the list of cost containment expenses specified in SSAP No. 85 4.a.		None	None	No standard lists.		
NJ does not currently include this information in MLR calculations.	None currently.		Not currently in use.		None	No statutory basis	Do not include.		

NJ requires carriers in the individual and small group markets to submit loss ratio reports by August 1 (small group) or August 15 (individual) for the preceding calendar year. We do not require submission of loss ratio reports for the large group market.	Rule is there, but lacks enforcement because late development and dissemination of form.		All non-group business requires annual rate filing including complete historical loss ratio experience data. All HMO business requires annual filing with most recent 12 months actual loss ratio experience.		For the 2009 reporting year, there is a confidential break out between small group, individual, and large group. Ohio revised code 3923.022 states: The statement of aggregate expenses filed pursuant to this section separately detailing an insurer's individual, small group, and large group business shall be considered work papers resulting from the conduct of a market analysis of an entity subject to examination by the superintendent under division (C) of section 3901.48 of the Revised Code, except that the superintendent may share aggregated market information that identifies the premiums earned as reported under division (C)(1)(a) of this section, the administrative expenses reported under division (C)(1)(i) of this section, the amount of commissions reported under division (C)(1)(f) of this section, the amount of taxes paid as reported under division (C)(1)(d) of	Small group requires actuarial certification that the insurer meets the rate corridor.	We do require this.		
As noted above, small employer is due by August 1 and individual is due by August 15. Claims are calculated using a six month claim runout to June 30; this explains the delay in reporting.	April 15th		With respect to rate filings, timing depends on the company's annual filing cycle. With respect to financial statements, company's follow the NAIC requirements.		Reporting is required April of the following year.	Annual certification pursuant to 36 OS 6518 - B. Each small employer carrier shall file with the Insurance Commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this act and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.	Due by April 1 of next year.		

The format is very simple. For the carrier as a whole, we require premiums, incurred claims, and refunds if required. Detail for incurred claims is paid claims during the reporting year, six months claim runout, and a nominal residual reserve. An actuarial certification is required, but supporting documentation is not.	Can check some of answers on I-SITE.		Companies submit incurred claims and earned premium data. Incurred claims typically state the incurred date and paid through date but no other supporting documentation.		This is the first year for this reporting breakout. We will review any additional data necessary such as Annual Statements, rate filings, and additional reporting on the Ohio Annual Report of Ohio Health Insurance Business in order to check for consistency. The Ohio Annual Report of Ohio Health Insurance Business is a web based statistical reporting form.	Small group: Historical incurred claims to earned premium	Oregon data shown separately for individual, small group, association & trust, large group. For each category, shown for # Members, Total Number of Member Months,Total Prem Earned, Total Medical Claims Costs, Medical Loss Ratio, Avg Prem Per Member/Per Month Reporting Year, Avg Prem Per Member/Per Month Prior Year, % Change in Prem Per Member/Per Month from Prior Year.		

All MLR information is publicly available. The reports themselves are public documents when received. The Department prepares annual summaries of loss ratio information at the company level (the same level of detail as reported), including actual individual and small group loss ratios and estimated aggregate and large group loss ratios. These reports are available upon request and are also posted on the Department's web site.	Plan is to provide reference for comparison of choices by consumers.		Annual financial statement data is available to the public. Rate filing data may or may not be available to the public on the Department website depending upon whether or not the company has filed for trade secret status.		Most data in the Ohio Annual Report of Ohio Health Insurance Business is made available through a public records request. The only reporting that is not made public is the market breakout for administrative expenses pursuant to 3923.022(G).	35 OS. 6518c. A small employer carrier shall make the information and documentation described in subsection A of this section available to the Commissioner upon request. Except in cases of violations of this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.	All the data is available on our web site.			

NJ requires refunds to policyholders for any calendar year in which the minimum loss ratio requirement of 80% is not met. The typical practice is to pay a uniform percentage of premium refund to every policyholder of the carrier (without regard to the type of product or other characteristics). (The law would permit some other formula if approved by the Department.) Refunds can be paid directly by check or as a credit to future premiums if the policyholder is still with the carrier. In the small employer market, the calculation is made at the regulated entity basis (so Oxford HP and Oxford HI would have separate calculations). In the individual market, the calculation is made on an affiliated basis (so the experience of Oxford HP and Oxford HI would be combined).	Law would require it three years hence. Not yet developed, but similar to Medicare Supplement requirements.		Most common corrective actions are premium reductions or benefit increases as opposed to rebates. Medicare supplement refunds have been issued on a pro-rata basis.		N/A	No statutory basis	Do not require.		
	To be announced.		For Medicare supplement, refund calculations are due by May 31 of the following year.		N/A	Not applicable	N/A		
	Probably follow Medicare Supplement Policy rules.		For Medicare supplement, all policyholders in force as of December 31 of the reporting year.		N/A	Not applicable	N/A		

	Probably similar to Medicare Supplement Policy rules.		For Medicare supplement, notification mailed with check.		N/A	Not applicable	N/A		
	Up until the current time, it has been on rate renewals and examinations (5 years).		For non-group and HMO, annual rate filing is required and filings may be disapproved for use. Medicare supplement refund calculations are reviewed by actuary.		This is the first year this reporting has been required. We will work with each company that appears to be in violation to access the need for rate adjustments.	Small group: 36 OS 6515 - Rates for small group are prior approval. 36 OS 6518 - Annual certification of rates 36 O.S. 6515 - Rate changes are prior approval.	N/A		

	If detected, penalties for violations are set by law and issuer can ask for a hearing before the Superintendent of Insurance.		Disapproval letters notify filer of rights to hearing.		Pursuant to ORC 3923.022(E), the Superintendent may suspend the license of an insurer or assess fines. The statute is below. (E) If the superintendent determines that an insurer has violated this section, the superintendent, pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code, may order the suspension of the insurer's license to do the business of sickness and accident insurance in this state until the superintendent is satisfied that the insurer is in compliance with this section. If the insurer continues to do the business of sickness and accident insurance in this state while under the suspension order, the superintendent shall order the insurer to pay one thousand dollars for each day of the violation.	Small group: If a loss ratio was certified to be greater than the statutory 60% but the rate actually produced a loss ratio lower that the 60%, it would result in a filing violation. A violation could result in disapproval of the rate filing, submission of a new rate filing, refunds to policyholders and/or a fine.	N/A		
	To be analyzed.		Additional loss ratio tests, increased filings and review of expenses may require additional actuarial staffing.		We believe that this may impact the nature and volume of rate review in Ohio. In addition, if States are to participate in confirming administrative expense, possible revisions will need to be made to the Ohio Annual Report of Ohio Health Insurance Business (which requires change approved by the Ohio legislature). Any additional participation or oversight that Ohio may have on the Rebate administration would result in possible staffing increase. Insurers will also undoubtedly need additional resources to handle changes that stem from 2718.		New and different reporting requirements for MLRs. New requirements for rebate calculations.		

	Unknown.		Agree with Ohio response.		Costs- Regulators- Additional staffing Insurance Companies – Additional resources Consumers- Depending on how 2718 is interpreted, consumers in some states may subsidize the rebates for other states. Benefits- Regulators- Possible greater transparency Insurance Companies – Opportunity to find inefficiencies or opportunity to reprioritize resources. Consumers- Opportunity to receive rate relief in the form of rebates or adjusted		Costs of new requirements. Those who receive rebates will benefit, but I would expect rebates to be rare in Oregon, since we expect most carriers will meet MLRs most of the time.		
	Unknown.		All		All		Carriers will pay most costs of reporting, with states paying to compile. In Oregon we expect rebates to be rare.		
	Yes		Yes		Yes		Not known at this time.		

South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
The information provided in the AHIP chart for South Carolina is reasonably accurate for loss ratio guarantee filings. But, it is not complete in that it does not reflect the fact that premiums for all individual accident and health insurance policies must be submitted for prior approval and all individual major medical expense coverage policies must meet our additional requirements for closed blocks. Noted below are specific changes I would suggest to the AHIP chart. 1. Under the "State" column, include the following references: SC Code of Laws Section 38-71-310(B), 38-71-310(E) and 38-71-325. 2. Under the MLR Guidelines and Reporting Requirements, I would replace the current language with the following: Premium rates and requests for rate increases must be filed for prior approval. The Department may disapprove premium rates if the benefits provided in the policies or certificates are unreasonable in relation to the premiums charged. The Department uses the guidelines and filing requirements set forth in the NAIC Guidelines for Filing of Rates for Individual Accident and Health in assessing whether or not the to the premiums charged. Benefits are deemed reasonable in relation to the premium charged if the department. This guaranteed loss ratio must be equivalent to, or gr within the National Association of Insurance Commissioners' "Guidelines Insurance Forms." The statute sets forth additional requirements with re - filing of an anticipated loss ratio; - an independent annual audit of the loss ratio results each year; and	No response	No response	No response	No response	No response	No. Under the AHIP "MLR Guidelines & Reporting Requirements", the third bullet point for Virginia should refer to 5% rather than 10%. For policies with annual premiums of $1000 or more add 5% (not 10%) to the allowable MLRs.	The loss ratios stated in the chart are for the retrospective rebate requirement and the applicability also applies to the disability carrier that has the individual health plan. For the prospectively rating requirement, the loss ratio for the individual health plan is always 74% minus the premium tax rate (usually at 2%).	After reviewing the loss ratios applicable to individual major medical products it was discovered that list of applicable MLR's was incomplete. The minimum required anticipated loss ratio for comprehensive, major medical is 65% and the "guaranteed loss ratio" is optional and requires a partial refund of premium if the guaranteed loss ratios are not attained.	Yes	No response
SC permits different minimum loss ratios for a variety of factors as set forth in the NAIC Rate Filing Guidelines, including: type of renewal clause, size of average premium and coverage and factors requiring special consideration as set forth in Section 2.C. of the NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms.						Refer to Virginia regulation 14VAC5-130-60 C for the different MLR requirements.	Our state requires the MLR requirement for the individual line of business. A minimum loss ratio is required for the pool of the individual line of business per carrier, and the minimum MLR requirements are not based on plan size, plan type, number of years of operation, or other factors.		Wisconsin does not have any minimum MLR requirements for health insurance issued in the large group, small group or individual market.	
SC Code of Laws Section 38-71-310(E)(5) defines the term loss ratio to mean the ratio of incurred losses to earned premium by number of years of policy duration for all combined durations. In addition, the definitions and methodologies set forth in the NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms would be required to the extent they do not conflict with the code section noted above.						Virginia calculates MLRs based on a pure loss ratio approach – incurred claims (paid claims plus claim reserves) divided by earned premiums.	Washington calculates MLRs based on a pure loss ratio approach – incurred claims (paid claims plus claim reserves) divided by earned premiums.		Wisconsin does not have any minimum MLR requirements for health insurance issued in the large group, small group or individual market.	

Information provided in the NAIC annual and/or quarterly statements and the NAIC Accident and Health Insurance Policy Experience Exhibit related to the items noted above is received by the State. The Department does not have any set standards as to which administrative overhead costs may be allocated to processing claims or providing health improvements. However, these are only permitted in the loss ratio calculations to the extent they are considered "incurred claims" in the definitions provided for the Accident and Health Insurance Policy Experience Exhibit.						Virginia does not address or regulate administrative costs. They can not be included in the MLRs.	The administrative costs can not be included in the MLRs.			
The Department considers items such as low exposure and/or low loss frequency. In addition, we will consider reasonable actuarial and statistical methods for determining whether or not experience is credible.						Virginia evaluates company filings based on reasonable and acceptable actuarial standards. Virginia does not publish standards for credibility but evaluates the credibility assigned to a block of business by a company based on reasonable and acceptable actuarial standards.	Washington statutes require the actual loss ratio (regardless of the credibility) for prior calendar year the purpose of calculating rebate.			

Experience of plans with similar benefits is often considered for newer and smaller plans.						Virginia does not have special considerations, definitions, and methodologies relating to calculating MLR-related statistics for newer plans, smaller plans, different types of plans or coverage. All MLRs are calculated the same way.	Washington statutes require the actual loss ratio (regardless of the credibility) for prior calendar year the purpose of calculating rebate. The actual loss ratio is for the individual line of business.			
SC's loss ratio requirements are based upon a "pure" loss ratio and generally do not take into account any administrative expenses.						The primary difference appears to be that 2718 uses a loss ratio approach that includes administrative cost in the loss ratio whereas Virginia only allows the sum of paid claims and claim reserves in the incurred claims.	The major difference appears to be that 2718 uses a loss ratio approach that includes quality improvement cost and excludes taxes and fees from the premiums. The loss ratio in Washington is the incurred claims divided by the earned premiums which includes all taxes and fees.		Wisconsin does not have any minimum MLR requirements for health insurance issued in the large group, small group or individual market.	
For purposes of the loss ratio calculation, issuers are currently required to submit incurred losses and earned premiums as defined in the NAIC Accident and Health Insurance Experience Exhibit.						None	None			

No specific requirements.						None	None		Wisconsin law currently requires that all defined network plans have in place a written quality assurance program. A defined network plan is defined as a health benefit plan that requires or creates incentives for enrollees to use providers that are managed, owned, employed by or under contract with the insurer offering the plan. The program must be in writing and provide a summary of comprehensive quality assurance standards that identify, evaluate and remedy problems related to access to care and continuity and quality of care. The summary must include written guidelines for quality of care studies and monitoring, performance and clinical outcomes-based criteria, procedures for remedial action to address quality problems, including written procedures for corrective action, plans for gathering and assessing data, a peer review process, and a process to inform enrollees on the results of the insurer's quality assurance program.	
No specific requirements.						None	None		Wisconsin does not currently have any set criteria for identifying activities that improve health care quality.	
No specific requirements.						None	None		Wisconsin does not currently maintain lists of activities that improve health care quality.	
Not included.						None	None		Wisconsin law does not specify the methodology to be used in calculating the MLR, nor does it specify to what extent monies spent on improving health care quality may be factored into the calculation.	

For all plans, to the extent this information is required to be filed in the NAIC Accident and Health Insurance Experience Exhibit. For individual accident and health insurance policies, information required on SCID Form 1504 (attached) must accompany each rate filing, including loss ratios for the last 6 years adjusted to the current rate basis. In addition, information required to be filed in the NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms.						N/A	Washington statutes require the actual loss ratio (regardless of the credibility) for prior calendar year the purpose of calculating rebate. The actual loss ratio is for the individual line of business.		Wisconsin does not require annual submission of MLR-related statistics.			
For general loss ratio information, the Annual Statement is required to be filed by March 1 of each year. The NAIC Accident and Health Insurance Policy Experience Exhibit is required to be filed by April 1 of each year. For rate filings, information must be submitted with the filing. For loss ratio guarantee filings, an independent audit must be performed in the second quarter of each year and audited results must be reported to the Department not later than the date for filing the applicable Accident and Health Insurance Policy Experience Exhibit.						N/A	Our statute requires, by the last day of May each year, carriers issuing or renewing individual health benefit plans in this state during the preceding calendar year, file for review by the commissioner supporting documentation of its actual loss ratio and its actual declination rate for its individual health benefit plans offered or renewed in this state in aggregate for the preceding calendar year.					

Necessary supporting documentation varies by filing. The data elements and format typically used for submitting information would be as specified by the NAIC in the annual/quarterly statement instructions, the Accident and Health Insurance Policy Experience Exhibit, or the NAIC Guidelines for Filing of Rates for Individual Health Insurance forms, as applicable.						N/A	The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.			

Information filed in the annual/quarterly statement filings, the Accident and Health Insurance Policy Experience Exhibit is public information when filed and may be viewed by visiting the Department's main office. Rate filings are made public upon disposition by the Department. It is important to note that insurers may mark some portion of the filings as trademark/confidential.						All filings available for public access at the Bureau's offices.	The actual loss ratio for prior calendar year is public information.			

Insurers filing a loss ratio guarantee pursuant to 38-71-310(E) must provide refunds as follows: "affected South Carolina policyholders will be issued a proportional refund (based on premium paid) of the amount necessary to bring the actual aggregate loss ratio up to the anticipated loss ratio standards referred to in item (1) above. The refund must be made to all South Carolina policyholders insured under the applicable policy form as of the last day of the year at issue if the refund would equal five dollars or more. The refund must include statutory interest from the end of the year at issue until the date of payment. Payments must be made during the third quarter of the next year. "						N/A	If the actual loss ratio for the preceding calendar year is less than the required loss ratio standard, a remittance is due and the following shall apply: (a) The carrier shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the required loss ratio (as stated in the above Table minus the premium tax rate).		Wisconsin does not have a minimum MLR for individual, large group, or small group health coverage. The laws provide for a 65% minimum loss ratio for individual Medicare supplement policies and 75% for group Medicare supplement policies. Medicare supplement insurers are required to provide a refund to policyholders if, on the basis of the experience as reported, the benchmark ratio since inception exceeds the adjusted experience ratio since inception. The refund calculation must be done on a statewide basis for each type of policy form. The refund shall include interest and must be made by September 30 following the experience year upon it is based.	
By the due date of the filing of the applicable Accident and Health Insurance Experience Exhibit.						N/A	b) The remittance to the Washington state health insurance pool is the percentage calculated in (a), multiplied by the premium earned from each enrollee in the previous calendar year. Interest shall be added to the remittance due at a five percent annual rate calculated from the end of the calendar year for which the remittance is due to the date the remittance is made.		For Medicare supplement refunds, a refund calculation form reporting experience of the prior year must be submitted for each type of Medicare supplement policy annually by May 31.	
See response to item 1.						N/A	Any remittance required to be issued under this section shall be issued within thirty days after the actual loss ratio is deemed approved or the determination by an administrative law judge if there is any dispute regarding the calculation of the actual loss ratio.		Please see response to 1 above.	

No specific requirements. Any reasonable method would be considered. However, the statute requires payment of interest from the end of the year at issue to the date of payment. Payments must be made during the third quarter of the next year.						N/A	(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used as directed by the pool board of directors.		Wisconsin law does not specify the method that must be used when notifying enrollees of rebates owed or paying the rebates	
SC Code of Laws Section 38-71-310(E)(3) require an independent audit of loss ratio guarantee filing. These independent audits are reviewed by the Department. If refunds are not provided in accordance with the statues, the appropriate disciplinary action will be taken. All individual accident and health insurance rates/requests for rate increases are required to be submitted for prior approval unless a loss ratio guarantee is submitted. The Department has not had any problems with insurers complying with this requirement. However, if a rate filing were not submitted in accordance with the statute, then the Department could take appropriate disciplinary action including requiring a refund of premium and/or fining the company.						Virginia does not currently enforce loss ratio requirements except if a rate increase filing is received. If a rate increase is not warranted, the filing is disapproved. If it appears that the form will not meet minimum loss ratio standards, then our only recourse is to withdraw the approval of the form.	None		Wisconsin does not have any minimum MLR requirements for health insurance issued in the large group, small group or individual market.	

The Department may impose administrative penalties in accordance with SC Code of Laws Section 38-2-10 for non-compliance with any SC statue. An aggrieved insurer has the right to appeal decisions of the Department through our Administrative Law Court.						N/A	If carriers fail to submit the loss ratio filing or the required rebate to Washington State Health Insurance Pool, we would have an enforcement action against the carrier.			
There will certainly be more scrutiny given to the rates and rating procedures of insurers. New data and reporting requirements will require additional resources for both insurers and regulators.						We are unsure how to respond; therefore, we haven't provided a response to these questions.	Yet to be determined.		In order to comply with Section 2718, Wisconsin must develop and maintain a system for collecting, analyzing and reporting MLR and other rating data on insurers in the individual, large group, and small group markets. To accomplish this we will require, at a minimum, the services of a consulting actuary, the use of internal information technology staff for filing system development and maintenance, and the use of internal market analysis staff.	

Benefits • Coverage should be made available (eventually) to all consumers • There should be greater transparency in rates and rating. • There is the implied hope that this will restrain the high increases in rates from year to year. Costs • Additional manpower and other resources needed by insurers to make products conform to new requirements. • Potential higher rates with new mandates on coverage. • Additional strains on regulators dealing with tight budgets and additional regulatory duties.						We are unsure how to respond; therefore, we haven't provided a response to these questions.	Yet to be determined..		The direct and indirect costs and benefits are yet to be determined.	
All						We are unsure how to respond; therefore, we haven't provided a response to these questions.	Yet to be determined.		The stakeholders that will be impacted by such benefits and costs include, at a minimum, insurance department staff, health insurers, and consumers.	
Yes. We would expect to see variances by the noted factors.						We are unsure how to respond; therefore, we haven't provided a response to these questions.	Yet to be determined.		Whether the impacts will vary by insurance market, plan type, or geographic area is yet to be determined.	